DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2008

Centers for Disease Control and Prevention

Justification of Estimates for Appropriation Committees

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PERFORMANCE DETAIL

EFFECTS OF CONTINUING RESOLUTION ON PERFORMANCE TARGETS

Given the uncertainty of final FY 2007 appropriation levels at the time CDC developed the performance targets for the FY 2008 Congressional Justification, the FY 2007 targets were not modified to reflect differences between the President's Budget and the Continuing Resolution funding levels. Enacted funding may require modifications of the FY 2007 performance targets. Only one performance measure, located in the Environmental Health section, reflects an adjustment in its FY 2007 target due to the Continuing Resolution.

SUMMARY OF PERFORMANCE TARGETS AND REPORTING PERFORMANCE MEASURES

The table below provides a summary of CDC's performance measures.

SUMMARY OF TARGETS AND RESULTS							
FY	Total Targets	Results Reported		Targets			
		Number	%	Met	Not Met		% Met
					Total	Improved	
2003[1]	131	128	98%	95	33	8.3	74%
2004[2]	90	82	91%	53.61	28.39	10.39	65%
2005[3]	134	107	80%	72.84	34.16	12.16	68%
2006[3]	148	87	59%	70.67	16.33	7.5	81%
2007[3]	121	N/A	N/A	N/A	N/A	N/A	N/A
2008[3]	121	N/A	N/A	N/A	N/A	N/A	N/A

[1] FY 2003 data have been revised based on updated information.
[2] FY 2004 reflects the results of multiple targets for some measures within the performance plan.
[3] FY 2005 – FY 2008 performance plans include one measure which is double-counted, serving as both an efficiency measure and an outcome measure as a result of the 2005 PART process.

PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY TABLE

PROGRAM	(DOLLARS IN MILLIONS) FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007	NARRATIVE RATING
2002 PART Programs				
317 Immunization Program	$425.1	$425.1	$0	Adequate
Breast and Cervical Cancer	$201.4	$201.4	$0	Adequate
Diabetes	$62.8	$62.8	$0	Adequate
Domestic HIV/ AIDS Prevention	$652.1	$745.1	$93.0	Results Not Demonstrated
2003 PART Programs				
State and Local Preparedness [1]	$823.7	$698.3	($125.4)	Results Not Demonstrated
2004 PART Programs				
Buildings and Facilities	$133.6	$20.0	($113.6)	Adequate
Occupational Safety and Health	$253.0	$253.0	$0	Adequate
Infectious Diseases Control [2]	N/A	N/A	N/A	Adequate
Sexually Transmitted Diseases / Tuberculosis	$294.1	$294.1	$0	Adequate
2005 PART Programs				
Environmental Health	$149.3	$149.3	$0	Adequate
Global AIDS Program	$121.2	$121.2	$0	Focus Countries – Moderately Effective; Other Bilateral - Adequate
Global Immunization	$144.4	$144.4	$0	Effective
Health Statistics	$109.0	$109.9	$0.9	Moderately Effective
Strategic National Stockpile	$491.4	$581.3	$89.9	Moderately Effective
2006 PART Programs				
Chronic Disease Prevention	$834.2	$834.2	$0	Moderately Effective
Birth Defects and Developmental Disabilities	$124.5	$124.5	$0	Moderately Effective
Injury Prevention and Control	$138.4	$138.4	$0	Moderately Effective
Biosurveillance	$78.4	$88.2	$9.8	Results Not Demonstrated
Bioterrorism: Upgrading CDC Capacity	$136.6	$136.6	$0	Results Not Demonstrated

[1] Funding levels for State and Local Preparedness reflect the entire Upgrading State and Local Capacity line.
[2] Infectious Diseases has been reorganized and no longer exists as a budget item.
[3] Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator ($603.7 million to date in FY 2006), as part of the Emergency Plan for AIDS Relief.

Funding requested for FY 2008 will allow CDC's PART programs to continue working toward their long-term and annual performance goals and measures, as well as actions to enhance program performance. Progress toward these goals and measures are reported in the Detail of Performance Analysis in the Performance Detail section.

For those programs with a Results Not Demonstrated (RND) rating, including Domestic HIV/AIDS Prevention and State and Local Preparedness, CDC recommends that funding be continued at requested levels because of the

significant progress being made toward the programs' PART Recommendations. Further, both programs anticipate undergoing a comprehensive PART re-review during the 2007 budget cycle.

For the 2006 cycle, CDC had five programs undergo the PART process: Chronic Disease Prevention, Birth Defects and Developmental Disabilities, Injury Prevention and Control, Biosurveillance, and Bioterrorism: Upgrading CDC Capacity. A brief overview of PART review findings and recommendations is provided in the narrative justifications for CDC programs that were assessed through PART in CY 2002 – CY 2006. Further detail may be found at www.ExpectMore.gov.

DETAIL OF PERFORMANCE ANALYSIS

The legend below provides detail for the icons referenced within the Detail of Performance Tables. Note the addition of the Secretary's 500-Day Plan.

DETAIL OF PERFORMANCE LEGEND	
E	Efficiency Measure
HHS#	HHS Strategic Plan Goal
HP#	Healthy People 2010 Objective
O	Outcome Measure
PAR	Performance and Accountability Report
PART	Program Assessment Rating Tool
*#	President's Management Agenda Initiative
500#	Secretary's 500-Day Plan: 1 – Transform the Healthcare System 2 – Modernize Medicare and Medicaid 3 – Advance Medical Research 4 – Secure the Homeland 5 – Protect Life, Family, and Human Dignity 6 – Improve the Human Condition around the World

INFECTIOUS DISEASES

IMMUNIZATION AND RESPIRATORY DISEASES

Efficiency Measure	FY	Target	Result
1. Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S. [E]	*2008*	**Reduce inventory depots by 50%**	1/2009
	2007	Reduce inventory depots by approximately 17%	1/2008
	2006	Award contract to centralize distribution, validate existing baseline	Yes (Met)
	2005	Establish estimated baseline of inventory points in the contiguous states	>400 (Met)
Data Source: Grantee annual report (VFC Management Survey), grantee interviews, and site visits were used to gather the baseline information. A VMBIP semi-annual survey instrument is being developed and will be administered to grantees to track vaccine storage locations.			
Data Validation: Data submitted from grantees will be analyzed by the CDC program staff and validated through a regularly scheduled review process.			
Cross Reference: HHS-8			

Efficiency Measure 1:

The Vaccine Management Business Improvement Project (VMBIP) is a CDC initiative aimed at increasing the efficiency, visibility, and management of publicly purchased vaccines by centralizing and consolidating vaccine inventory and distribution. Currently, publicly purchased vaccine, including vaccine purchased by the Section 317 program, is held at various third party distribution depots or in state run depots. It is estimated that 400 storage locations exist. Even though the current system works, it is inefficient. The large number of depots results in redundancy of distribution resources, reduces the efficiency of distribution, and impedes the program's ability to track vaccine.

CDC, through VMBIP, contracted with McKesson Specialty Distribution in September 2006 to consolidate national inventory in significantly fewer inventory depots than currently exist and distribute vaccine through a streamlined central system. The expected efficiencies gained from consolidation of vaccine depots include improved management of vaccine inventory through use of distribution best practices and increased visibility of the location of vaccines throughout the public vaccine supply chain. As phased implementation progresses, the number of locations holding vaccines will decrease until full implementation is complete by FY 2009 and vaccine inventory depots are reduced by 98 percent. The first pilot sites which are Washington State, California, the City of Chicago, and Maryland will begin distributing through the centralized distribution system in February 2007.

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.			
Measure	**FY**	**Target**	**Result**
1. The number of indigenous cases of paralytic polio [1], rubella [1], measles [1], *Haemophilus influenzae* invasive disease (type b and unknown types) [2], diphtheria [3], congenital rubella syndrome [4,5], and tetanus [3] will remain at or be reduced to 0 by 2010. [O]		*Paralytic Polio*	*Paralytic Polio*
	2008	**0**	9/2009
	2007	0	9/2008
	2006	0	9/2007
	2005	0	0 (Met)
	2004	0	0 (Met)
	2003	0	0 (Met)
		Rubella	*Rubella*
	2008	**15**	9/2009
	2007	15	9/2008

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.			
Measure	**FY**	**Target**	**Result**
	2006	15	9/2007
	2005	15	8 (Exceeded)
	2004	15	7(Exceeded)
	2003	15	7 (Exceeded)
		Measles	*Measles*
	2008	**50**	9/2009
	2007	50	9/2008
	2006	50	9/2007
	2005	50	42 (Exceeded)
	2004	50	10 (Exceeded)
	2003	50	32 (Exceeded)
		Haemophilus influenzae	*Haemophilus influenzae*
	2008	**150**	9/2009
	2007	150	9/2008
	2006	150	9/2007
	2005	150	226 b = unknown (Unmet)
	2004	150	196 b + unknown (Unmet)
	2003	175	259 b+unknown (Unmet)
		Diphtheria	*Diphtheria*
	2008	**5**	9/2009
	2007	5	9/2008
	2006	5	9/2007
	2005	5	0 (Exceeded)
	2004	5	0 (Exceeded)
	2003	5	0 (Exceeded)
		Congenital rubella Syndrome	*Congenital rubella Syndrome*
	2008	**5**	9/2009
	2007	5	9/2008
	2006	5	9/2007
	2005	5	0 (Exceeded)
	2004	5	0 (Exceeded)
	2003	5	1 (Exceeded)
		Tetanus	*Tetanus*
	2008	**25**	9/2009
	2007	25	9/2008
	2006	25	9/2007
	2005	25	5 (Exceeded)
	2004	25	6 (Exceeded)
	2003	25	6 (Exceeded)

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.			
Measure	**FY**	**Target**	**Result**
2. Reduce the number of indigenous cases of mumps in persons of all ages from 666 (1998 baseline) to 0 by 2010. [O][5]		*Mumps*	*Mumps*
	2008	**200**	9/2009
	2007	200	9/2008
	2006	200	9/2007
	2005	200	314 (Unmet)
	2004	200	258 (Unmet)
	2003	250	231 (Exceeded)
3. Reduce the number of indigenous cases of pertussis among children under 7 years of age. [O]		*Pertussis*	*Pertussis*
	2008	**2,300**	9/2009
	2007	2,300	9/2008
	2006	2,300	9/2007
	2005	2,300	7,347 (Unmet)
	2004	2,300	6,850 (Unmet)
	2003	2,500	3,719 (Unmet)
Data Source: National Notifiable Disease Surveillance System (NNDSS), National Congenital Rubella Syndrome Registry (NCRSR), Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs.			
Data Validation: NNDSS - CDC receives reports of notifiable diseases from the 50 state health departments, New York City, the District of Columbia, and five U.S. Territories. These reports are initiated when health care providers suspect or diagnose a case of a notifiable disease. Clinical laboratories also report results consistent with reportable diseases. Reporting of nationally notifiable diseases to CDC by the states is voluntary and only mandated (i.e., by state legislation or regulation) at the state level. All case reports, especially for low incidence and internationally quarantinable diseases, must be verified by the appropriate state officials. NNDSS case counts are likely incomplete, and therefore, these data are considered to represent a minimum number of cases. State reporting practices and some administrative procedures used in processing the NNDSS data may impact surveillance data reports and analyses. CDC staffs provide technical assistance relevant for data verification to ensure data accuracy, completeness, and timeliness. Specifically, assistance includes: computer specifications and software for reporting from state and territorial health departments, development and implementation of procedures to validate surveillance data, and identification of incomplete records, transmission errors, and deviations from expected numbers. NCRSR - CDC maintains the NCRSR with supplemental information to NNDSS. The registry includes data only on cases classified as confirmed or compatible. Cases are also classified as indigenous (exposure within the United States) and imported (exposure outside the United States) and are tabulated by year of birth. In contrast, cases reported to the NNDSS are tabulated by year of report. ABCs is an active laboratory and population-based surveillance system for invasive bacterial pathogens of public health importance, and currently operates in 10 sites in the U.S. For each case of invasive disease in the surveillance population, a case report with basic demographic information is completed and bacterial isolates are sent to CDC and other reference laboratories for additional laboratory evaluation. The ABCs program provides routine laboratory audits to ensure the completeness of data collection. Each month, CDC staff review data and communicate potential errors to state personnel for evaluation. Performance standards for active surveillance have been established in each site to permit aggregation of data collected via somewhat different approaches. Detailed instructions for completion of case report forms ensure consistency across sites. Timeliness and completeness of reporting in ABCs is evaluated using threshold percentages of isolate collection and enrollment into special studies. Surveillance "fatigue" or operational problems are assessed using isolate shipping schedules, audit sensitivities, and the timeliness of the audit data being completed by set deadlines.			
Cross Reference: Measure 1 - HHS-1, HP-14.1a, 14.1b, 14.1c, 14.1e, 14.1h, 14.1i, 14.1j, PART, 500-1; Measure 2 - HHS-1, HP-14.1f, 500-1; Measure 3 - HHS-1, HP-14.1g, 500-1			

[1] All ages.
[2] Children under five years of age.
[3] Persons under 35 years of age.
[4] Children under one year of age. Result column indicates all cases – indigenous and imported. Imported cases will be differentiated in 2007, but those data are not yet available.
[5] Results column indicates all cases – indigenous and imported. Imported cases will be differentiated in 2007, but those data are not yet available.

Goal 1, Performance Measure 1:

Haemophilus influenzae type B (Hib) – Conjugate vaccines for the prevention of Hib are highly effective. Hib is no longer the leading cause of meningitis among children younger than five years old in the U.S. The number of possible cases reported increased from 196 cases in 2004 to 226 cases in 2005, and the FY 2005 target of 150 cases remains unmet. In accordance with the Healthy People 2010 goal, this measure includes both type b cases (for which vaccine would be effective) and those with unknown serotypes. The number of cases with unknown serotypes that are actually type b cannot be confirmed. Neither Healthy People 2010 targets nor GPRA targets have been adjusted to account for cases with unknown serotype. Therefore, while this goal remains unmet, the actual number of type b cases (both serotyped and not) for which the vaccine would have been effective may have remained the same or even decreased; the increase in cases from 2004 to 2005 may be explained by these disease reporting challenges. To address this issue of incomplete serotyping, CDC is working with state partners to provide technical assistance for enhanced Hib surveillance and laboratory support.

Goal 1, Performance Measure 2:

Provisional data indicate that the mumps disease targets will not be met in 2005 or 2006 due to a large national mumps outbreak that began in December 2005 and continued through 2006. Although the highest number of cases was reported from states in the Midwest, most states reported increases in number of mumps cases. The majority of cases occurred among persons 18-25 years of age, many of these persons were vaccinated with two doses, reflecting the 90%-95% effectiveness of this vaccination schedule. As a result of this outbreak, vaccination recommendations were modified to better define evidence of immunity, ensure routine vaccination for health care workers, and address additional vaccination needs for persons in outbreak settings. Prior to 2004, there had been some progress in mumps disease reduction – reflected by a two-thirds reduction in cases from 1998 (666 cases) to 2003 (231 cases). However, the number of mumps cases in 2004 increased to 258 and CDC did not meet the 2004 goal of 200 cases.

Goal 1, Performance Measure 3:

Pertussis (whooping cough) is a highly contagious, vaccine-preventable bacterial illness characterized by prolonged and severe cough and sometimes pneumonia. Although pertussis affects all age groups, complications and death are most frequently recognized among unvaccinated infants. The 2005 target was to reduce the number of pertussis cases among children under seven years of age to 2,300. The actual number of cases in this age group was 7,347. Most of these cases occurred among children who are not fully protected from disease. Children are not fully protected until they receive four doses of the vaccine by 15-18 months. Many cases occur among infants who are exposed to disease before they receive their first vaccination at two months of age. Introduction in 2005 of adolescent and adult versions of improved acellular pertussis vaccines with tetanus and diphtheria booster (DTap vaccine) provides new opportunities for reducing severe pertussis and its complications in all age groups in the U.S.

GOAL 2: ENSURE THAT 2-YEAR-OLDS ARE APPROPRIATELY VACCINATED.			
Measure	**FY**	**Target**	**Result**
1. Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: -4 doses DTaP vaccine[1] -3 doses Hib vaccine -1 dose MMR vaccine[2] -3 doses hepatitis B vaccine -3 doses polio vaccine -1 dose varicella vaccine -4 doses pneumococcal conjugate vaccine (PCV7)[3]	*2008*	**90% coverage**	8/2009
	2007	90% coverage	8/2008
	2006	90% coverage	8/2007
	2005	90% coverage	DTaP 86%; Hib 94%; MMR 92%; Hepatitis B 93%; Polio 92%; Varicella 88% (Exceeded, with the exception of DTaP and Varicella)
	2004	90% coverage	DTaP 86%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 88% (Exceeded, with the exception of DTaP and Varicella)

GOAL 2: ENSURE THAT 2-YEAR-OLDS ARE APPROPRIATELY VACCINATED.			
Measure	**FY**	**Target**	**Result**
	2003	90% coverage	DTaP 96%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 85% (Exceeded, with the exception of Varicella)
Data Source: Data are collected through the National Immunization Survey (NIS) and reflect calendar years.			
Data Validation: The NIS uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population, nationally, and by region, state, and selected large metropolitan areas. The NIS, a telephone-based survey, is administered by random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians are asked about the vaccines–with dates–that appear on the child's "shot card" kept in the home; demographic and socioeconomic information is also collected. At the end of the interview with parents or guardians, survey administrators request permission to contact the child's vaccination providers. Providers are then contacted by mail to provide a record of all immunizations given to the child. Examples of quality control procedures include 100% verification of all entered data with a sub-sample of records independently entered. The quarterly data files are reviewed for consistency and completeness by CDC's National Immunization Program, Immunization Services Division - Assessment Branch and CDC's National Center for Health Statistics' (NCHS) Office of Research and Methodology. NCHS also conducts a separate qualitative assessment of 10% of the records. Random monitoring by supervisors of interviewers' questionnaire administration styles and data entry accuracy occurs daily. Annual methodology reports are available to the public for review.			
Cross Reference: HHS-1, HP-14.24a, PART, PAR, 500-1			

[1] Due to a shortage in vaccine and temporary change in recommendations, 3 doses were reported from 2002 – 2003.
[2] Includes any measles-containing vaccine.
[3] Performance targets for any newly recommended vaccines, such as pneumococcal conjugate and influenza vaccines, are reported in GPRA five years after an ACIP recommendation is made and once NIS data become available. The timing of data availability may also be impacted by the age group for which that particular vaccine is recommended.

Goal 2, Performance Measure 1:

The ACIP Recommended Childhood and Adolescent Immunization Schedule recommends routine vaccination of children for the above diseases. The target of 90 percent coverage was met in 2005 for most vaccines with the exception of varicella and the fourth dose of DTaP.

In 2005, the coverage rate for four doses of DTaP containing vaccine did not yet achieve the 90 percent goal. However, the coverage rate for the fourth dose has steadily increased since the change to a four dose schedule, as recommended by the ACIP in 1991. The ACIP also recommends that a fifth dose be given to children between four and six years of age for full vaccination. This goal continues to be difficult to achieve because it requires that the fourth dose be given to the child between 15 and 18 months of age. The administration of DTaP tends to coincide with regular well-baby visits through the third dose; however, the fourth dose does not, requiring a visit specifically for this purpose. Coverage rates are 96 percent for the first three DTaP doses. Although the first three doses are considered to be most critical, CDC and the ACIP feel strongly that the fourth dose and also the fifth dose are important for full vaccination. Varying state requirements for the four-dose vaccine schedule may have also led to a slower increase in coverage. In 2002 and 2003, CDC modified reporting on DTaP from four doses to three doses because vaccine shortages limited the availability of the fourth dose. This change was made because the ACIP recommends that if this vaccine is in short supply, or not available, the fourth dose of DTaP may be dropped. The performance reporting change was temporary and reporting for the fourth dose has now been implemented.

Varicella is the most recently introduced vaccine that has a measurable target. Varicella vaccination rates are rising with coverage at only 43 percent in 1998 and reaching 88 percent in 2005. CDC is close to meeting the 90 percent varicella vaccines coverage goal, and is continuing to increase coverage. CDC/HHS and the ACIP recently made policy changes for the use of varicella (chickenpox) vaccine to include a recommendation for routine two-dose varicella vaccination of children. This new recommendation is expected to further reduce the number of cases and outbreaks of varicella in the United States.

The prevention of pneumococcal infections with PCV is becoming more important because of problems with treatment due to antibiotic resistance. The ACIP added PCV to the 2001 Recommended Childhood Immunization Schedule. Accountability for performance targets will begin with CY 2006 data which will not be available until the next budget cycle. The vaccination coverage level for PCV in 2005 is 83 percent for three doses.

GOAL 3: INCREASE THE PROPORTION OF ADULTS WHO ARE VACCINATED ANNUALLY AGAINST INFLUENZA AND EVER VACCINATED AGAINST PNEUMOCOCCAL DISEASE.			
Measure	**FY**	**Target**	**Result**
1. Increase the rate of influenza and pneumococcal vaccination in persons 65 years of age and older to 90% by 2010.	*2008*	**Influenza 85% Pneumococcal 80%**	1/2010
	2007	Influenza 74%; pneumococcal 69%	1/2009
	2006	Influenza 74%; pneumococcal 69%	1/2008
	2005	Influenza 74%; pneumococcal 69%	Influenza 59.6% (Unmet) pneumococcal 56.2% (Unmet)
	2004	Influenza 74%; pneumococcal 69%	Influenza 65% (Unmet); pneumococcal 57% (Unmet)
	2003	Influenza 74%; pneumococcal 69%	Influenza 66% (Unmet); pneumococcal 56% (Unmet)
2. Increase the rate of influenza and pneumococcal vaccination among non-institutionalized high-risk adults aged 18 to 64 years to 60% by 2010.	*2008*	**Influenza 40%; pneumococcal 35%**	1/2010
	2007	Influenza 32%; pneumococcal 22%	1/2009
	2006	Influenza 32%; pneumococcal 22%	1/2008
	2005	Influenza 32%; pneumococcal 22%	Influenza 25.3% (Unmet) pneumococcal 22.6% (Met)
	2004	Influenza 32%; pneumococcal 22%	Influenza 35% (Met); pneumococcal 21% (Unmet)
	2003	Influenza 32%; pneumococcal 22%	Influenza 34% (Met); pneumococcal 21% (Unmet)
Data Source: National Health Interview Survey (NHIS).			
Data Validation: NHIS is a cross-sectional household interview survey. Households chosen for interviews are a probability sample representative of the target population. The annual response rate is more than 90 percent of eligible households in the sample. NHIS has three modules: 1) The basic module remains largely unchanged from year to year and allows for trend analysis. Data from more than one year can also be pooled to increase the sample size for analytic purposes. The basic module contains a family core, a sample adult core, and a child core through which data are collected on the family unit and from one randomly selected adult and child. 2) Periodic modules collect more detailed information on some of the topics included in the basic module. 3) Topical modules respond to new data needs as they arise. Data are collected through a personal household interview conducted by staff employed and trained by the U.S. Bureau of the Census according to procedures delineated by CDC. Data are reviewed and analyzed extensively to ensure their validity and reliability. The survey sample is designed to yield estimates that are representative and that have acceptably small variations. Before the actual survey, cognitive testing is performed by CDC's Questionnaire Design Research laboratory, and pretests are conducted in the field. Once collected, data are carefully edited, checked, and compared to data from earlier surveys and/or independent sources. Staff members calculate descriptive statistics and perform in-depth analyses, which result in feedback on the analytic usefulness of the data.			
Cross Reference: Measure 1 - HHS-1, HP-14.29a, 14.29b, 500-1; Measure 2 – HHS-1, HP-14.29c, 14.29d, 500-1			

Goal 3, Performance Measure 1:

During the past decade, vaccination coverage levels among older adults increased steadily as CDC implemented national strategies and promoted adult and adolescent immunization among healthcare providers and state and local governments. Influenza vaccination coverage levels among the elderly have increased from 30 percent in 1989 to 65 percent in 2004. However, data suggest that influenza vaccination levels may have reached a plateau, and in 2005 a decrease to coverage of 60 percent was observed. This is most likely related to unprecedented shortages of influenza vaccination in the 2004-2005 season and delays of influenza vaccinations in the 2005-2006 seasons.

Despite recent vaccine availability issues, the increase in vaccination coverage began to slow before 2000. The plateau is not fully understood. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain an influenza vaccination target of 74 percent for 2005, 2006 and 2007. There was an increase in vaccine supply to over 100 million doses in the 2006-2007 influenza season, and it is anticipated that supply will continue to increase in upcoming years. CDC and partners such as the National Influenza Vaccine Summit will continue to aggressively promote vaccination. Additionally, the FY 2007 and FY 2008 President's Budgets request funds to increase demand for influenza vaccine. Therefore, CDC has increased the target in 2008 to 85 percent coverage for influenza vaccination.

An increasing proportion of older adults also reported receipt of pneumococcal vaccination, from 15 percent in 1989 to 57 percent in 2004. Although the proportion of older adults receiving pneumococcal vaccine in 2005 (56.2%) remained consistent with the 2004 result, in neither year was the goal of 69% met. Adult vaccination rates are slowly increasing, and CDC has worked with the Centers for Medicaid and Medicare Services to raise the reimbursement rate for influenza and pneumococcal vaccines. Similar challenges apply to pneumococcal vaccination in adults as influenza vaccination. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain the same targets for 2005, 2006 and 2007 for pneumococcal vaccination in this age group. However, due to an anticipated increase in aggressive vaccine promotion efforts, especially focused on influenza vaccination, but also including messages about pneumococcal vaccination, CDC has raised the 2008 goal to 80 percent.

Goal 3, Performance Measure 2:

The ACIP Recommended Adult Immunization Schedule recommends vaccination for influenza for adults at high risk of complications each year and pneumococcal vaccination for those persons at high risk. Current levels of coverage among adults vary widely among different age, risk, and racial and ethnic groups. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza and pneumococcal vaccines, may make fewer visits for preventive care, and may not recognize they are recommended to receive influenza and pneumococcal vaccinations. Persons with high-risk conditions, such as heart disease and diabetes, remain at increased risk from these diseases. For this population of high risk adults 18 to 64 years of age, the pneumococcal vaccination goal of 22% has been met. However, as was noted for adults 65 years of age and older, a decrease in influenza vaccine coverage was seen in 2005 for the 18 to 64 year old population. It is likely that issues with vaccine availability, distribution, and recognition of priority group recommendation affected coverage status.

GOAL 4: PROTECT AMERICANS FROM INFECTIOUS DISEASES – INFLUENZA.			
Measure	**FY**	**Target**	**Result**
1. By 2010, enhance preparedness for pandemic influenza by establishing influenza networks globally through bilateral cooperative agreements that are actively producing usable samples for testing as measured by geographic and population coverage.	*2008*	**20 networks**	12/2008
	2007	20 networks	12/2007
	2006	9 networks	13 (Exceeded)
	2005	9 networks	12 (Exceeded)
	2004	N/A	9 networks; 1 with 100% geographic coverage and 70% population coverage; 8 with 10-40% geographic coverage and 10-40% population coverage per country network.
	2003	Baseline	1 network; 60% geographic coverage; and, 60% population coverage per country network
Data Source: International bi-lateral cooperative agreement data and specimens received through the WHO Global Influenza Surveillance Network.			
Data Validation: CDC provides on-site technical assistance and review and analyzes the data for submittal of influenza samples and isolates for seasonal and pandemic influenza. Given that global coverage is necessary for both routine influenza virus monitoring and development of capacity to identify avian influenza for containment and response, ability to test of avian and other influenza and submit timely specimens is critical. Increasing geographic participation and enhancing capacity in more countries greatly increases the probability of detecting a case or cluster of H5N1.			
Cross Reference: HHS-4, 5, PART, 500-4			

Goal 4, Performance Measure 1:

This measure tracks CDC's efforts to increase the number of influenza networks globally to enhance early detection of viruses with pandemic potential and improve vaccine decision-making. Early detection of pandemic viruses will benefit the international community by allowing the maximum lead time possible to develop pandemic vaccines, thus reducing morbidity and mortality globally. The accomplishment of this measure will also establish the influenza surveillance foundation necessary to conduct influenza burden studies, formulate vaccine policy, and reduce illness due to influenza through vaccination. Ideally, a network will be a nationwide system developed to collect virologic and epidemiologic data for influenza by establishing five or more sites with good distribution throughout the country. Each site will consist of a local laboratory and one or more clinics or hospitals for data collection. However, some flexibility of this definition may be needed based on geographic and resource considerations.

Currently, CDC supports 13 influenza surveillance networks globally through cooperative agreements. Support is provided through on-site training, the provision of technical assistance, and funding for equipment and supplies. As part of the overall plan to develop networks in Asia, key staff have been located in Asia with CDC assignments to Vietnam, Laos, Cambodia and the Western Pacific Office of WHO. CDC provides technical assistance and support for enhancing or developing influenza surveillance networks. In addition, CDC provides support and assistance to foreign governments for the establishment of surveillance networks in Cambodia, Korea, Indonesia, Pakistan, India, Philippines, Thailand, Mongolia, Malaysia, China Vietnam, Kazakhstan and Pacific Public Health Surveillance Network (a consortium of seven countries and territories including Cook Islands, Fiji, Guam, Wallis and Futuna, Palau and Tonga). Finally, CDC provided critical support to partners in Department of Defense (DOD) at both Naval Medical Research Unit (NAMRU)-2 in Jakarta and NAMRU3 in Cairo. The collaborations enhance technical assistance regionally and improve sharing of international specimens. Expansion of the bilateral cooperative agreements in FY 2007 is planned with a focus on countries outside of Asia affected by avian influenza.

GOAL 5: PROTECT AMERICANS FROM INFECTIOUS DISEASES - PNEUMOCOCCAL DISEASE.			
Measure	**FY**	**Target**	**Result**
1. By 2010, reduce the rates of invasive pneumococcal disease in children under 5 years of age to 46 per 100,000 and in adults aged 65 years and older to 42 per 100,000. [O]		*Children under 5 years of age*	*Children under 5 years of age*
	2008	**46**	6/2009
	2007	47	6/2008
	2006	48	6/2007
	2005	50	21.3 (Exceeded)
		Adults 65 years and older	*Adults 65 years and older*
	2008	**42**	6/2009
	2007	45	6/2008
	2006	47	6/2007
	2005	55	38.8 (Met)
Data Source: The Active Bacterial Core surveillance (ABCs)/ Emerging Infections Program Network.			
Data Validation: The data are collected by 10 states through active contact with all clinical laboratories in population catchment areas; the data are sent to CDC monthly for review, editing and cleaning. States conduct audits for missed cases either monthly or in some cases bi-yearly. Pneumococcal isolates are collected and validated at three quality-controlled reference laboratories.			
Cross Reference: HHS-1, HP-14.5, PART			

Goal 5, Performance Measure 1:

Incidence of pneumococcal disease fell between 2001 and 2005. These data indicate that CDC is on track to reach disease reduction targets. Progress is aided by the introduction of the pneumococcal conjugate vaccine that was licensed for use in children in the U.S. in 2000. Vaccinating children has reduced disease in adults through reduced transmission. However, some challenges remain. Supplies of the conjugate vaccine were inadequate between 2001 and 2004. CDC has worked with the vaccine manufacturer, ACIP, and professional organizations to promote optimal and equitable use of vaccine during times of shortage. Vaccine supply is now adequate. However, a small increase in disease caused by strains not covered by the pneumococcal conjugate vaccine has been detected, and CDC is monitoring trends in these strains.

GOAL 6: IMPROVE VACCINE SAFETY SURVEILLANCE.			
Measure	**FY**	**Target**	**Result**
1. Improve capacity to conduct immunization safety studies by increasing the total population of managed care organization members from which the Vaccine Safety Datalink (VSD) data are derived annually to 13 million by 2010.	*2008*	**11 million**	6/2009
	2007	10 million	6/2008
	2006	10 million	6/2007
	2005	10 million	9.0 million (Unmet)
	2004	10 million	7.5 million (Unmet)
	2003	10 million	7.5 million (Unmet)
	2002	Baseline	7.5 million
Data Source: VSD			
Data Validation: Annual reports and other published information from the VSD-participating managed care organizations.			
Cross Reference: HHS-1, 2, 4, HP-14.31, 500-3			

Goal 6, Performance Measure 1:

The VSD is a collaborative effort involving CDC and several large managed care organizations (MCOs). The VSD was established primarily to assess immunization safety issues in the U.S. by conducting scientific studies utilizing a large-linked database (LLD) that incorporates administrative data sources at each MCO and also utilizing additional site resources such as medical charts. Each participating site gathers information regarding the vaccination and medical records of millions of children and adults. Collectively, the data from VSD studies are derived from participating MCOs that contain more than nine million members, of which the VSD project collects comprehensive medical information for more than 5.5 million people annually. The VSD enables population-based immunization and safety research studies to compare the incidence of health problems between vaccinated and unvaccinated people. The performance target for this goal was not met in FY 2005 because increasing populations in LLDs is contingent on cooperating entities, resources, and technologies. This performance measure reflects only one aspect of CDC's immunization safety surveillance; CDC's immunization safety activities are not limited to this one project.

HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION

Efficiency Measure	FY	Target	Result
1. Decrease the amount of time in the review and oversight process for directly-funded Community-Based Organizations (CBOs), as reflected in the number of CDC programs for CBOs. [E]	*2006*	3 program announcements	3 current announcements (Met)
	2005	3 current announcements	3 current announcements (Met)
	2004	N/A	3 program announcements
	2003	Baseline	9 current program announcements
2. Improve the accuracy of the portrayal of the U.S. HIV epidemic in national reports by increasing the number of states using confidential name-based HIV reporting methods with level funding, thereby enabling CDC to report standardized HIV data from a larger number of jurisdictions. [E]	*2008*	**48**	12/2008
	2007	44	12/2007
	2006	42	46 (Exceeded)
	2005	Baseline	38
3. Reduce the amount of time it takes to award grantees' unobligated funds by meeting the Procurement and Grant Office's (PGO) key performance targets without increased funding. [E]	*2008*	**29**	10/2008
	2007	35	10/2007
	2006	40	29 (Exceeded)
	2005	Baseline	52 days
Data Source: Measures 1 and 2 - HIV/AIDS Reporting System (HARS) is used to collect state HIV and AIDS data. Data for measure 2 reflect end of calendar year performance. Measure 3 - The data source for this measure is PGO's annual KPI tracking report.			
Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them.			
Cross Reference: HHS-8			

Efficiency Measure 1:

In FY 2004, CDC consolidated six program announcements for CBOs into one program announcement. The consolidation decreased the administrative work at CDC required to develop, publish, compete, review and award six different program announcements. This consolidation also provided CDC with the opportunity to improve oversight of grantees by reducing the number of different grant requirements which project officers are expected to know. Finally, the new program announcement included a set of core performance indicators to monitor and evaluate grantee performance.

The review process used to evaluate applications involves convening special emphasis panels, obtaining subject matter experts, conducting pre-decisional site visits and budget negotiations, and developing technical reports for each program announcement. By consolidating the six program announcements, CDC was able to streamline the review and oversight process, thereby decreasing staff time and cost for all of these functions.

This efficiency measure was a temporary measure that was used to demonstrate the efficiency of CDC staff in developing, publishing, and completing the review and award of funds for one comprehensive program announcement for directly funded CBOs compared with six different announcements. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Efficiency Measure 2:

As available treatments prolong the lives of those infected with HIV and slow the progression to AIDS, AIDS data are increasingly insufficient to describe the national epidemic. Accurate, reliable, and comparable HIV data are needed from all states to describe the epidemic nationally. Although all states have implemented HIV reporting, it occurs via a number of methods. As of December 2006, 46 states and five territories and Washington, D.C. have adopted confidential, name-based reporting and four states implement code-based systems. Except for HIV, all other reported infectious diseases, including AIDS, are routinely reported to states using name-based reporting systems. Personal identifiers are removed from this data prior to submission to CDC. Because of the lack of standard methods for reporting diagnoses and the potential for duplication of cases arising from these multiple methods, HIV

data are not sufficiently accurate and reliable to provide data on HIV prevalence nationwide. CDC's policy is to accept HIV infection and AIDS case surveillance data only from areas conducting confidential name-based reporting because this reporting has been shown to routinely achieve high levels of accuracy and reliability. Further, only confidential name-based HIV reporting integrated with AIDS surveillance data can be used by states to remove duplicate cases reported to CDC's national surveillance database. For these reasons, in July 2005, CDC recommended that states conduct HIV reporting using the same name-based approach currently used for AIDS surveillance nationwide. This measure will monitor changes from coded systems to confidential, name-based reporting. Such changes will increase the proportion of HIV cases that are included in the national database, thereby providing a more accurate picture of the epidemic nationwide and enabling better targeting of federal HIV resources.

Efficiency Measure 3:

CDC funds both non-research and research funding opportunity announcements for HIV (Domestic), STDs and TB. Unobligated funds (i.e. carryover) are common for grantees due to various circumstances such as: unspent personnel funds realized while grantees' are advertising jobs; unspent contractual funds when grantees publish program announcements for subcontractors; savings realized in purchases of equipment or services; and in-kind resources acquired by grantees from donations to cover approved expenses.

For FY 2005, HIV (Domestic), STD and TB programs carryover requests averaged 52 days for processing. In order to meet PGO's key performance indicator (KPI) target, CDC will improve the average time to process request to award by meeting PGO's KPI of 29 days for carryover requests as the end target.

This is an important efficiency for CDC for two reasons. First, the unobligated funds are reobligated to program, mission-direct grantee activities and are needed in a timely fashion. Second, this efficiency measure will decrease the amount of staff time spent on administrative activities.

OVERARCHING HIV/AIDS PREVENTION

Twenty-five years into the epidemic, HIV is still a fatal infection for which there is no cure. Available treatments have dramatically improved the lives of those infected. However, treatments must be taken over the course of a lifetime, have serious side-effects, and are costly. Further, one-quarter of those who are infected do not know of their infection and do not benefit from treatment. The chief goal of CDC's HIV efforts is to reduce the number of new infections in the U.S.

GOAL 1: BY 2010, REDUCE BY 25% THE NUMBER OF NEW HIV INFECTIONS IN THE U. S., AS MEASURED BY A REDUCTION IN THE NUMBER OF HIV INFECTIONS DIAGNOSED EACH YEAR AMONG PEOPLE UNDER 25 YEARS OF AGE, FROM 2,100 IN 2000 TO APPROXIMATELY 1,600 IN 2010.			
Measure	**FY**	**Target**	**Result**
1. Reduce the rate of HIV infections diagnosed each year among people under 25 years of age.[1] [O]	*2008*	8.6/100,000 in 33 states	11/2009
	2007	<4000 cases in 30 areas	11/2008
	2006	Overall: 2,420 reported cases in 30 areas	11/2007
	2005	Overall: 1,800 reported cases in 25 states	2,700 in 25 states; (Unmet) 3,605 in 30 areas 7.4/100,000 in 33 states
	2004	Overall: 1,900 reported cases in 25 states	2,606 in 25 states; (Unmet) 3,465 in 30 areas (Unmet);
	2003	N/A	2,286 in 25 states; 3,134 in 30 areas; 6.9/100,000 in 33 states
2. Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 247 cases. [O]	*2008*	**<100 cases**	11/2009
	2007	<100 cases	11/2008
	2006	<100 cases	11/2007
	2005	<100 cases	58 (Exceeded)
	2004	<100 cases	48 (Exceeded)
	2003	<139 cases	69 (Exceeded)

GOAL 1: BY 2010, REDUCE BY 25% THE NUMBER OF NEW HIV INFECTIONS IN THE U. S., AS MEASURED BY A REDUCTION IN THE NUMBER OF HIV INFECTIONS DIAGNOSED EACH YEAR AMONG PEOPLE UNDER 25 YEARS OF AGE, FROM 2,100 IN 2000 TO APPROXIMATELY 1,600 IN 2010.
Data Source: HIV/AIDS Reporting System (HARS).
Data Validation: HIV data collection systems vary between areas (e.g., name-based code, coded identifier, name-to-code data collection systems). CDC recommends that all states and territories adopt confidential name-based HIV surveillance systems. As of December 2006, 46 states, the District of Columbia and five territories use confidential name-based HIV surveillance, while two states use name-to-code-based systems, and five states and the District of Columbia use code-based methods. The 25 states with mature, stable HIV surveillance systems at baseline are: Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. The 30 area comparison group includes the 25 states plus Florida, Iowa, Nebraska, New Mexico, and the U.S. Virgin Islands. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". The 33 states included in targets for rates include the 29 states listed above and Alaska, Kansas, New York, and Texas. Targets for 2008 have been converted to rates; previous targets were set based on the number of cases reported. Population data come from the Bureau of Census and are limited to the population of persons under 25 years of age in the 33 states. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate estimates of trends for that year.
Cross Reference: Measure 1 – HHS-1, PART, PAR, 500-6; Measure 2 - HHS-1, HP-13.17, PAR, 500-6

[1]This measure was first reported in FY 2004 and therefore, targets begin in FY 2004. However, actual performance is shown for previous years because the data was available, even though it was not reported in the form of a measure.

Goal 1, Performance Measure 1:

The rate of HIV infection diagnoses among persons under 25 years of age each year is the best data available to monitor new HIV infections on an annual basis. HIV infections occurring in this group are likely to have been acquired recently and thus are a relatively good proxy measure of HIV incidence. In addition, it enables CDC to examine yearly trends in reported cases by risk, demographic, and geographic variables. The data are from a national surveillance system that collects demographic, clinical, and behavioral information on all AIDS cases diagnosed in the U.S., as well as HIV cases diagnosed in states with name-based HIV reporting requirements. Data for 2008 will be reported as rates from 33 states with long-standing HIV reporting. Rates provide a more accurate methodology of measuring program performance over time, as they provide a percentage for the population affected. Targets for previous years were set based on the number of cases reported. While annual data on HIV incidence are not yet available, CDC has estimated HIV incidence in the past. After dramatic reductions from a peak of 150,000 infections per year in the mid-1980's, annual HIV incidence is hypothesized to be level in the U.S. However, recent outbreaks of syphilis among men who have sex with men have raised concerns that HIV incidence may be rising rather than decreasing. CDC is working to reduce incidence in this and other high risk groups. Recent initiatives to greatly expand HIV testing are expected to have a substantial impact on the proportion of infected persons who are diagnosed. Therefore, in the short term, the number of cases diagnosed and reported to CDC is expected to rise. The FY 2007 and FY 2008 targets have been adjusted accordingly. In the long-term, helping people learn of their infection and providing them prevention services is expected to decrease the number of new infections.

Goal 1, Performance Measure 2:

Surveillance data published through 2005 show sharply declining trends in perinatal AIDS cases since the mid-1990s. This decline was strongly associated with increasing zidovudine use in pregnant women who were aware of their HIV status. More recently, improved treatment likely delays the onset of AIDS for HIV-infected children. With efforts to maximally reduce perinatal HIV transmission and increase treatment for those infected, cases are likely to remain low.

DOMESTIC HIV/AIDS PREVENTION

GOAL 2: DECREASE THE NUMBER OF PERSONS AT HIGH RISK FOR ACQUIRING OR TRANSMITTING HIV INFECTION.			
Measure	**FY**	**Target**	**Result**
1. Among HIV-infected persons 18 years of age and over, reduce the proportion that had high-risk sex with a negative partner or partner of unknown status. [O]	*2008*	**<14%**	11/2009
	2007	<11%	11/2008
	2006	<11%	Not available (Unmet)
	2005	<10%	Not available (Unmet)
	2004	<10%	13.4% (median) (Unmet)
	2003	N/A	17.0% (median)
Data Source: CDC Supplement to the HIV/AIDS Surveillance (SHAS), CDC Medical Monitoring Project (MMP) (Beginning in 2007).			
Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. The SHAS project was discontinued in June 2004. Data for 2004 reflect six months of data.			
Cross Reference: HHS-1, 500-6			

Goal 2, Performance Measure 1:

Because every new HIV infection is the result of transmission from an infected person, encouraging infected persons to adopt safe behaviors is one of the highest priorities of HIV prevention. Helping those who are infected to adopt safer behaviors is a key strategy of CDC's HIV initiative, Advancing HIV Prevention (AHP). In 2004, CDC asked state grantees to prioritize interventions with those who are HIV-infected, and included prevention with infected persons as a key component of their new directly-funded CBO program. Targets and actual performance estimates represent the median figure from 16 participating areas. The survey used until 2004 for this measure was discontinued that year. Beginning in 2007, data for this measure will be collected through the new Medical Monitoring Project (MMP), which is to collect data beginning in 2007. While in transition to the MMP, the national survey was not conducted in 2005 or in 2006. Therefore, data will not be available for 2005 and 2006.

GOAL 3: BY 2010, INCREASE BY 13% THE PROPORTION OF HIV-INFECTED PEOPLE WHO KNOW THEY ARE INFECTED, AS MEASURED BY THE PROPORTION DIAGNOSED BEFORE PROGRESSION TO AIDS (BASELINE: 76% IN 2000; TARGET FOR 2010: 85%).			
Measure	**FY**	**Target**	**Result**
1. Among persons with HIV infection, increase the proportion diagnosed before progression to AIDS. [O]	*2008*	**79%**	11/2009
	2007	79%	11/2008
	2006	79%	11/2007
	2005	80%	77% (Unmet)
	2004	80%	78% (Unmet)
	2003	N/A	78% Data are from 30 areas with stable HIV reporting systems
2. Increase the percentage of HIV-positive tests with post-test counseling sessions reported from CDC funded test sites. [O]	*2008*	**75%**	10/2010
	2007	75%	10/2009
	2006	75%	10/2008
	2005	80%	10/2007
	2004	80%	71% (Unmet)
	2003	75%	71% (Unmet)

GOAL 3: BY 2010, INCREASE BY 13% THE PROPORTION OF HIV-INFECTED PEOPLE WHO KNOW THEY ARE INFECTED, AS MEASURED BY THE PROPORTION DIAGNOSED BEFORE PROGRESSION TO AIDS (BASELINE: 76% IN 2000; TARGET FOR 2010: 85%).

Data Source: CDC HIV/AIDS Reporting System, CDC HIV Counseling and Testing System (CTS).

Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. As of December 2006, 46 states, the District of Columbia and five territories conduct confidential, name-based reporting for persons diagnosed with HIV who have not developed AIDS. CDC recommends that all states and territories adopt confidential name-based HIV surveillance. The 30 areas in measure 1 are Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, U.S. Virgin Islands, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Cross Reference: Measure 1 – HHS-1, HP-13.15, PART, 500-6; Measure 2 – HHS-1, 500-6

Goal 3:

As deaths due to AIDS have decreased and the rate of new infections has remained stable, the number of persons living with HIV/AIDS has increased. If incidence does not decrease, the number of persons living with HIV and AIDS is expected to continue to increase slightly each year. Further, of the estimated 1,039,000 to 1,185,000 persons infected with HIV in the U.S., one-fourth are unaware of their infection. Reducing the incidence of both new infections and HIV associated morbidity and mortality will require earlier testing and improved access to prevention and care services for persons with HIV. Research shows that persons who are aware of their infection are more likely to adopt behaviors to protect themselves and their partners. Thus, promoting knowledge of serostatus among those who are infected is essential in preventing new infections. In 2006, as part of the President's initiative to Continue the Fight Against HIV/AIDS in America, CDC issued revised recommendations for HIV testing for adults and adolescents, aimed at increasing the proportion of persons who are aware of their infection. The recommendations call for voluntary, routine testing of all adults and adolescents, without regard to expressed risk and simplify the consent process. CDC has begun to plan for other key parts of the initiative, including programs to directly provide testing to jurisdictions with the highest numbers of new cases.

Goal 3, Performance Measure 1:

This measure is an indicator of the percentage of persons who learn of their infection before the development of an AIDS-defining condition. Compared with early testers, late testers are more likely to be young, black or Hispanic and to receive HIV testing because of illness. Early testers are more likely to seek testing because of self-perceived risk. The percentage of persons diagnosed with HIV and AIDS simultaneously should decrease over time if a greater proportion of HIV-infected persons find out their HIV status earlier. Activities related to these measures include efforts to increase knowledge of HIV status through voluntary counseling and testing, and to encourage routine testing for HIV in health care settings.

Goal 3, Performance Measure 2:

Each year, approximately two million publicly funded HIV tests are reported from over 11,000 sites, each with varying rates of clients returning for their test results. There was a reported increase from 69.3 percent in 2000 to 71 percent in 2004 in the percentage of HIV-positive test results from CDC-funded sites with post test counseling reported. CDC is working with all grantees to continue improving the return rates for HIV-positive test results. HIV rapid tests now allow return of preliminary HIV test results "while you wait" increasing the number of people who receive their preliminary results. HIV positive test results still require confirmatory testing, with results shared at post-test counseling sessions. In FY 2002, two jurisdictions reported incomplete data and were not included in the overall calculation.

GOAL 4: BY 2010, INCREASE TO AT LEAST 80% THE PROPORTION OF HIV-INFECTED PEOPLE WHO ARE LINKED TO APPROPRIATE PREVENTION, CARE, AND TREATMENT SERVICES, AS MEASURED BY THOSE WHO REPORT HAVING RECEIVED SOME FORM OF MEDICAL CARE WITHIN 3 MONTHS OF THEIR HIV DIAGNOSIS (2001 BASELINE: 79%).

Measure	FY	Target	Result
1. Increase the proportion of HIV-infected people who received some form of medical care within 3 months of HIV diagnosis. [O] (Data are from interviews taken from a sample of persons in 16 areas.)	*2008*	**80%**	11/2009
	2007	80%	11/2008
	2006	80%	Not available (Unmet)
	2005	80%	Not available (Unmet)
	2004	80%	86.1% (Exceeded)
	2003	N/A	83.3%

GOAL 4: BY 2010, INCREASE TO AT LEAST 80% THE PROPORTION OF HIV-INFECTED PEOPLE WHO ARE LINKED TO APPROPRIATE PREVENTION, CARE, AND TREATMENT SERVICES, AS MEASURED BY THOSE WHO REPORT HAVING RECEIVED SOME FORM OF MEDICAL CARE WITHIN 3 MONTHS OF THEIR HIV DIAGNOSIS (2001 BASELINE: 79%).
Data Source: CDC SHAS, MMP (Beginning in 2007).
Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. The SHAS project was discontinued in June 2004. Data for 2004 reflect six months of data.
Cross Reference: HHS-1, PART, 500-6

Goal 4, Performance Measure 1:

This measure reflects linkage to care after initial diagnosis. A physician should evaluate an HIV-infected person soon after receiving the initial positive results. However, many persons are not evaluated because of fear or lack of access to medical care. The data through 2004 for this measure were collected through interviews with HIV-infected persons in 16 areas. That survey has been discontinued. Beginning in 2007, data will be collected using the new MMP. While in transition to the MMP, the national survey was not conducted in 2005 or in 2006. Therefore, data will not be available for 2005 and 2006.

GOAL 5: STRENGTHEN THE CAPACITY NATIONWIDE TO MONITOR THE EPIDEMIC; DEVELOP AND IMPLEMENT EFFECTIVE HIV PREVENTION INTERVENTIONS; AND EVALUATE PREVENTION PROGRAMS.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of states and the District of Columbia that conduct HIV case reporting in adults and adolescents.	*2008*	**50 states and D.C.**	10/2008
	2007	50 states and D.C.	10/2007
	2006	50 states and D.C.	50 states and DC; 46 states and DC use confidential, name-based reporting (Met)
	2005	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2004	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2003	50 states	49 states and D.C.; 34 use confidential, name-based reporting (Unmet)
Data Source: CDC HIV/AIDS Reporting System (HARS).			
Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them.			
Cross Reference: HHS-1, 500-6			

Goal 5, Performance Measure 1:

Historically, new AIDS cases (AIDS incidence) were the basis for assessing needs for prevention and treatment programs. However, potent new antiretroviral therapies are delaying the development of AIDS in many HIV-infected persons and AIDS data are no longer sufficient to describe the epidemic. Data on HIV are now needed. Currently, all states have implemented some form of HIV reporting. HIV reporting in the U.S. is conducted using one of three methods: 1) name-based; 2) code; and, 3) name-to-code. As of December 2006, 46 states, the District of Columbia, and five territories use confidential name-based reporting systems for HIV case surveillance. CDC recommends that all states use confidential name-based methods for HIV case surveillance and is working with states to implement and improve HIV reporting and is implementing methods to estimate HIV incidence nationally.

SEXUALLY TRANSMITTED DISEASES

CDC supports STD prevention and control by: 1) monitoring disease trends using national and local data to focus and assess current prevention activities; 2) conducting behavioral, clinical, and health services research and program evaluation to provide a scientific base for improving program efforts; 3) providing education and training through guideline development, 10 regional STD/HIV Prevention Training Centers, and programs to ensure that health care

professionals are prepared to provide optimal STD treatment, care, and prevention services; and, 4) building national partnerships for STD prevention to educate health professionals, the public, and policymakers about the importance of STD prevention and the impact of STDs on the health of Americans, particularly women and infants, adolescents, and minority populations; and 5) providing financial, direct personnel, and technical assistance to state and local health departments to deliver clinical and prevention services.

Two foci are syphilis elimination and infertility prevention. CDC also supports special surveillance studies for human papillomavirus (HPV) and herpes simplex 2 (HSV-2); supports epidemiologic, behavioral, laboratory and health services research on a variety of STDs; provides program support, training and health communications for national STD prevention programs; and develops recommendations for HPV vaccines and implementation issues pertinent to such vaccines.

GOAL 6: REDUCE STD RATES BY PROVIDING CHLAMYDIA AND GONORRHEA SCREENING, TREATMENT, AND PARTNER TREATMENT TO 50% OF WOMEN IN PUBLICLY FUNDED FAMILY PLANNING AND STD CLINICS NATIONALLY.

Measure	FY	Target	Result
1. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics. [O]	*2005*	<5% median	6.3% (Unmet)
	2004	<5% median	6.3% (Unmet)
	2003	<5% median	5.9% (Unmet)
	2002	<5% median	5.6% (Unmet)
2. Reduce the incidence of gonorrhea in women aged 15 to 44. [O]	*2005*	<250/100,000 women	276/100,000 women (Unmet)
	2004	<250/100,000 women	278/100,000 women (Unmet)
	2003	<250/100,000 women	268/100,000 (Unmet)
	2002	<250/100,000 women	279/100,000 (Unmet)

Data Source: CDC STD Morbidity Surveillance System, CDC Infertility Prevention Program (IPP), the U.S. Department of Labor National Job Training Program, CDC National Center for Health Statistics (NCHS), and National Diagnostic and Therapeutic Index by IMS America, Ltd.

Data Validation: Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff. Pelvic Inflammatory Disease (PID) hospitalization data are collected by the NCHS. Data for PID initial visits to physicians are collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.

Cross Reference: Measure 1 - HHS-1, HP-25.1a, 500-1; Measure 2 - HHS-1, HP-25.2, 500-1; Measure 3 - HHS-1, 500-1; Measure 4 - HHS-1, HP-25.6, 500-1

Goal 6, Performance Measure 1:

In 2005, the median chlamydia test positivity among 15-24 year-old women who were screened during visits to selected family planning clinics in all states and outlying areas was 6.3 percent (range: 3.0 percent to 20.3 percent). However, in nearly all states, chlamydia positivity was greater than the Healthy People 2010 objective of three percent. The source for the data is the CDC IPP. The continued expansion of screening programs to populations with higher prevalence of disease, use of more sensitive diagnostic tests, and high rates of reinfection from untreated sex partners likely contributed to the increase in overall median positivity. This measure has been revised for FY 2006 (see below).

Goal 6, Performance Measure 2:

The U.S. experienced a 74.3 percent decline in the reported rate of gonorrhea from 1975 to 1997. After a small increase in 1998, the gonorrhea rate has decreased slightly since 1998.

Among women aged 15 to 44, the 2005 gonorrhea rate was 276 per 100,000 population, which is above the target rate of 250. Although increased screening (usually associated with simultaneous testing for chlamydial infection), use of more sensitive diagnostic tests, and improved reporting may account for a portion of the recent increase, true increases in disease in some populations and geographic areas also appear to have occurred. The source for these data is the STD Morbidity Surveillance System, CDC. This measure has been revised for FY 2006 (see below).

GOAL 7: REDUCE THE INCIDENCE OF PRIMARY AND SECONDARY SYPHILIS.			
Measure	**FY**	**Target**	**Result**
1. Increase the percentage of U.S. counties with an incidence of P&S syphilis in the general population of 4/100,000. [O]	*2005*	>95% of counties	93.8% (Unmet)
	2004	>95% of counties	94.5% (Unmet)
	2003	>95% of counties	95% (Met)
	2002	>92% of counties	94% (Exceeded)
2. Reduce the racial disparity (reported ratio is black: white). [O]	*2005*	11:1	5.4:1 (Exceeded)
	2004	13:1	5.6:1 (Exceeded)
	2003	15% to 14:1	38% reduction to 5:1 (Exceeded)
	2002	15% to 17:1	50% reduction to 8:1 (Exceeded)
Data Source: STD Morbidity Surveillance System, CDC.			
Data Validation: Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
Cross Reference: Measure 1 - HHS-1, HP-25.3; Measure 2 - HHS-3, HP-25.3, 500-1			

Goal 7, Performance Measure 1:

The rate of primary and secondary (P&S) syphilis in the U.S. declined by 89.7 percent from 1990 through 2000. In 2005, 93.8 percent of U.S. counties had an incidence of P&S syphilis in the population equal or below four per 100,000. Recent outbreaks of syphilis among men who have sex with men (MSM) have been reported, reflecting an increase in risky sexual behavior in this population and negatively affecting the significant reductions in P&S syphilis in the past decade. The rate of P&S syphilis increased slightly in 2005 from 2.7 in 2004 to 3.0 per 100,000 population. This increase was observed primarily in men (4.7 to 5.1 per 100,000 population), though syphilis rates in women increased slightly between 2004 and 2005 (0.8 to 0.9 per 100,000 population). Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 7, Performance Measure 2:

P&S syphilis remains an example of racial disparity in health, with 2005 rates among African Americans 5.4 times those among white Americans, down from a 64-fold differential at the beginning of the last decade. While substantially reduced from previous years, this disparity (5.4:1) is still much higher than that for other health outcomes: including infant mortality (2.5:1), and deaths attributable to heart disease (1.3:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. CDC aims to continue reducing this racial disparity. This measure has been revised for FY 2006 (see below).

GOAL 8: REDUCE THE INCIDENCE OF CONGENITAL SYPHILIS.			
Measure	**FY**	**Target**	**Result**
1. Reduce the incidence of congenital syphilis per 100,000 births. [O]	*2005*	<12	8.0 (Exceeded)
	2004	<12	8.8 (Exceeded)
	2003	<12	10.3 (Exceeded)
	2002	<12	11.4 (Exceeded)
Data Source: STD Morbidity Surveillance System, CDC			
Data Validation: Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
Cross Reference: HHS-1, HP-25.9, 500-1			

Goal 8, Performance Measure 1:

The continuing decrease in the rate of congenital syphilis likely reflects the substantial reduction in the rate of P&S syphilis among women that has occurred in the last decade. Between 1995 and 2005, the average yearly percentage decrease in the congenital syphilis rate was 15.8 percent. The average yearly percentage decrease in the rate of P&S syphilis reported among women for the years 1995 through 2005 was 16.0 percent. This measure has been revised for FY 2006 (see below).

Insufficient syphilis serologic testing and treatment of women for syphilis during pregnancy remains the major reason congenital syphilis persists in the U.S. When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in utero. This may result in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care. Each positive test in a child is considered a medical emergency with immediate health services follow-up. The absence of testing is often related to complete lack of, or late initiation of, prenatal care. Between 2004 and 2005, the overall rate of congenital syphilis decreased 12.1 percent in the U.S., from 9.1 to 8.0 cases per 100,000 live births.

Goals 9 and 10:

During the FY 2006 (CY 2004) budget process, CDC's STD Prevention program underwent a PART review by the Office of Management and Budget. This process helped CDC redirect and refine its performance measures for STD prevention and control. Based on its PART review, CDC revised its goals for STD prevention. CDC will track the following goals and measures (Goals 9 and 10) and will no longer report on goals six through eight, after reporting for their FY 2005 targets has been completed.

GOAL 9: BY 2010, REDUCE THE INCIDENCE OF PELVIC INFLAMMATORY DISEASE (PID) BY 15% (AS MEASURED BY INITIAL VISITS TO PHYSICIANS BY WOMEN AGES 15-44).

Measure	FY	Target	Result
1. Reduce the prevalence of chlamydia among high-risk women under age 25 by 15%. [O]	*2008*	**<10%**	10/2009
	2007	9.3%	10/2008
	2006	9.3%	10/2007
	2002	Baseline	10.1%
2. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics by 15%. [O]	*2008*	**<7%**	10/2009
	2007	6.3%	10/2008
	2006	6.3%	10/2007
	2002	Baseline	5.6%
3. Reduce the incidence of gonorrhea in women aged 15 to 44 by 15%. [O]	*2008*	**<280/100,000**	10/2009
	2007	278/100,000	10/2008
	2006	278/100,000	10/2007
	2002	Baseline	279/100,000

Data Source: The source for these data is the U.S. Department of Labor; U.S. Job Corps, IPP, CDC, and the STD Morbidity Surveillance System, CDC. 2002 data from the U.S. Job Corps are from 28 states and Puerto Rico. 2004 data are from 38 states and Puerto Rico.

Data Validation: Data from STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff. Data for PID initial visits to physicians are collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.

Cross Reference: Measure 1 - HHS-1, PART, 500-1; Measure 2 - HHS-1, HP-25.1a, 500-1; Measure; 3 - HHS-1, HP-25.2, 500-1

Goal 9, Performance Measure 1:

Data on the prevalence of chlamydial infection in defined populations have been useful to monitor disease burden and guide screening programs. For example, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program for economically disadvantaged women aged 16 to 24 who enter this program. Increased efforts to promote screening by medical practitioners are needed to achieve reductions in chlamydia in this and other populations. The FY 2008 target reflects what is achievable given current trends.

Goal 9, Performance Measure 2:

Chlamydia remains widespread and is a significant threat to women's health. Because chlamydia is usually asymptomatic and is most common among young women, CDC recommends annual chlamydia screening for sexually active women age 25 and under. This measure reflects chlamydia prevalence in programs receiving support from CDC. The FY 2008 target reflects what is achievable given current trends.

Goal 9, Performance Measure 3:

Chlamydia and gonorrhea are the most important preventable causes of infertility and potentially fatal tubal pregnancy. CDC conducts screening for chlamydia and gonorrhea to prevent PID from untreated infection. If not adequately treated, up to 40 percent of women infected with chlamydia or gonorrhea will develop infection (i.e., PID) in the uterus or fallopian tubes. PID can lead to chronic pelvic pain, infertility and ectopic pregnancy. These measures reflect the importance of reducing this adverse health outcome. The FY 2008 target reflects what is achievable given current trends.

GOAL 10: REDUCE THE INCIDENCE OF PRIMARY AND SECONDARY (P&S) SYPHILIS BY 12% AND CONGENITAL SYPHILIS BY 62%.			
Measure	**FY**	**Target**	**Result**
1a) Reduce the incidence of P&S syphilis in men per 100,000 population by 7%. [O]	*2008*	**<5/100,000**	10/2009
	2007	4.5/100,000	10/2008
	2006	Establish Baseline [1]	10/2007
1b) Reduce the incidence of P&S syphilis in women per 100,000 population by 65%. [O]	*2008*	**<1.0/100,000**	10/2009
	2007	0.8/100,000	10/2008
	2006	0.58/100,000	10/2007
	2002	Baseline	1.1/100,000
2. Reduce the incidence of congenital syphilis per 100,000 live births. [O]	*2008*	**<10/100,000**	10/2009
	2007	8.8/100,000	10/2008
	2006	8.8/100,000	10/2007
	2002	Baseline	11.4/100,000
3. Reduce the racial disparity of P&S syphilis by 63% (reported ratio is black:white). [O]	*2008*	**≤ 7 to 1**	10/2009
	2007	5.6 to 1	10/2008
	2006	5.6 to 1	10/2007
	2002	Baseline	8.1 to 1
Data Source: STD Morbidity Surveillance System, CDC.			
Data Validation: Data from STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
Cross Reference: Measure 1a – HHS-1, PART, 500-1; Measure 1b – HHS-1, PART, HP-25.3, 500-1; Measure 2 – HHS-1, HP-25.9, 500-1; Measure 3 - HHS-3, HP-25.3, 500-1			

[1] In FY 2002, the incidence of P&S syphilis in men was 3.8 per 100,000 (initial FY 2002 baseline). However, because of an outbreak of syphilis among men who have sex with men that occurred after 2002, CDC will report a new baseline for FY 2006. The overall goal for 2010 is a decrease in incidence of 12 percent as compared to the FY 2006 baseline.

Goal 10:

Syphilis, a genital ulcerative disease, is highly infectious, but easily curable in its early (primary and secondary – P&S) stages. If untreated, it can lead to long-term complications including nerve, cardiovascular and organ damage and even death. Congenital syphilis (transmission from mother to child) can cause stillbirth, death soon after birth, physical deformity and neurological complications in children who survive. Syphilis also facilitates the spread of HIV, increasing transmission of the virus at least two-to-five fold.

Goal 10, Performance Measure 1a:

Although the rate of P&S syphilis in the U.S. declined by 89.7 percent during 1990-2000, the rate of P&S syphilis remained unchanged between 2000 and 2001, and increased annually since 2002. Overall increases in rates during 2001-2004 were observed only among men, but in 2005, there was also a slight increase in the rate among women. Recent outbreaks of syphilis occurring among MSM have been reported and have been characterized by high rates of HIV co-infection and high-risk sexual behavior.

Goal 10, Performance Measure 1b:

Syphilis rates in women declined with the implementation of the Syphilis Elimination Plan (from 2.0/100,000 in 1999 to 0.9/100,000 in 2005). CDC will continue to strive to decrease syphilis cases among women, both to protect the health of women and to prevent congenital syphilis. Untreated early syphilis during pregnancy results in perinatal death in up to 40 percent of cases, and, if acquired during the four years preceding pregnancy, may lead to infection of the fetus in over 70 percent of cases. The FY 2008 target reflects what is achievable given current trends.

Goal 10, Performance Measure 2:

When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in *utero*. This often results in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care. The FY 2008 target reflects what is achievable given current trends.

Goal 10, Performance Measure 3:

Syphilis remains an example of racial disparity in health, with 2005 rates among African Americans 5.4 times those among white Americans, down from a 64-fold differential at the beginning of the last decade. The racial disparity (5.4:1) is higher compared to many other health outcomes including infant mortality (2.5:1), and deaths attributable to heart disease (1.3:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. The FY 2008 target reflects what is achievable given current trends.

TUBERCULOSIS

GOAL 11: PROGRESS TOWARDS TB ELIMINATION IN THE U. S. (DEFINED AS LESS THAN 1 CASE/1,000,000 POPULATION) BY ACHIEVING AN INTERIM TB RATE OF 1 CASE/100,000 POPULATION IN U.S.-BORN PERSONS AND 20 CASES/100,000 POPULATION IN FOREIGN-BORN PERSONS RESIDING IN THE U. S., AND 3 CASES/100,000 POPULATION OVERALL, BY 2010.			
Measure	**FY**	**Target**	**Result**
1. Decrease the number of persons with TB among US-born persons, foreign-born persons, and overall (per 100,000 population). [O]	*2008*	**US-born 2.6 ; Foreign-born 22.8; Overall 4.9**	9/2009
	2007	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	9/2008
	2006	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	9/2007
	2004	Baseline	US born: 2.6; Foreign-born: 22.8; Overall: 4.9
2. Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months).[1] [O]	*2008*	**>85%**	9/2011
	2007	88%	9/2010
	2006	88%	9/2009
	2005	88%	9/2008
	2004	88%	9/2007

GOAL 11: PROGRESS TOWARDS TB ELIMINATION IN THE U. S. (DEFINED AS LESS THAN 1 CASE/1,000,000 POPULATION) BY ACHIEVING AN INTERIM TB RATE OF 1 CASE/100,000 POPULATION IN U.S.-BORN PERSONS AND 20 CASES/100,000 POPULATION IN FOREIGN-BORN PERSONS RESIDING IN THE U. S., AND 3 CASES/100,000 POPULATION OVERALL, BY 2010.			
Measure	**FY**	**Target**	**Result**
	2003	88%	81.5% (Unmet)
	2002	88%	80.9% (Unmet)
	1999	Baseline	67.6%
3. Increase the percentage of TB patients with initial positive cultures who also have drug susceptibility results. [O]	*2008*	**95%**	9/2009
	2007	95%	9/2008
	2006	95%	9/2007
	2005	95%	94.6% (Unmet)
	2004	95%	93.9% (Unmet)
	1994	Baseline	74.7%
4. Increase the percentage of contacts of infectious (Acid-Fast Bacillus (AFB) smear-positive) cases that are placed on treatment for latent TB infection and complete a treatment regimen. [O]	*2008*	**> or = 43%**	12/2011
	2007	43%	12/2010
	2006	59%	12/2009
	2005	61%	12/2008
	2004	61%	12/2007
	2003	63%	43% (Unmet)
	2002	63%	42% (Unmet)
	1999	Baseline	45.5%
Data Source: Data are obtained from the national TB Surveillance System and the national Aggregate Reports for TB Program Evaluation.			
Data Validation: TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Data submitted via the national Aggregate Reports for TB Program Evaluation are checked for accuracy and inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.			
Cross Reference: Measure 1 - HHS-1, HP-14.11, PART, 500-1; Measure 2 – HHS-1, HP-14.12, 500-1; Measure 3 - HHS-1; Measure 4 - HHS-1, HP-14.13, 500-1			

[1]Data reports come to CDC after therapy is completed, which can be as long as two years.

Goal 11, Performance Measure 1:

TB is a leading infectious killer of young adults worldwide, claiming the lives of more than two million people each year. Approximately one third of the world's population is latently infected with the bacterium that causes TB. An estimated 10 to 15 million U.S. citizens have latent TB infection, and about 10 percent of these individuals will develop TB at some point in their lives. In 2005, TB cases declined for the 13th straight year and, from 2004 to 2005, reported cases of TB in the U.S. declined 2.9 percent (from 14, 515 to 14,097). Persons born outside the U.S. now account for more than half of all U.S. TB cases.

Goal 11, Performance Measure 2:

Because completion of TB treatment is the most effective way to reduce the spread of TB and prevent its complications, this objective is the highest priority for CDC's TB program. Its achievement is vital to reduce TB cases and to eventually eliminate TB. Patients who do not complete therapy within 12 months are often difficult to treat and require numerous interventions. Significant new efforts must be made to achieve this objective. CDC supports outreach workers, hired from language, cultural, and ethnic groups with high TB incidence to help meet this objective.

Outreach workers help patients complete treatment through directly observed therapy incentives and other adherence strategies. CDC and the CDC-funded Model TB Centers also design and implement training and educational aids for health department and healthcare providers to improve the skills they need to help achieve this objective. The proportion of persons who complete a curative course of treatment within 12 months of initiation rose from 67.6% in 1999 to 81.5% in 2003, however, improvement in this area is still needed.

Goal 11, Performance Measure 3:

Healthcare providers must know if a newly diagnosed infectious patient is infected with drug-sensitive or drug- resistant organisms so that appropriate drug therapy can be initiated. If this information is unknown, patients may receive inadequate treatment leading to the spread of drug-resistant organisms, additional morbidity, and mortality. The percentage of TB patients with initial positive cultures who have drug susceptibility results has increased dramatically over the past decade, from 74.7% in 1994 to 94.6% in 2005. Progress towards this measure is attributable to increased efforts of state and local health departments and hospital infection-control practitioners to address the resurgence of TB and increased funding for health department laboratories to purchase state-of-the-art equipment needed to perform more accurate and rapid laboratory testing and confirmation for TB and multi-drug resistant TB.

Goal 11, Performance Measure 4:

Completion of treatment for latent TB infection among contacts of infectious TB cases is a cornerstone of U.S. efforts to reduce TB and eliminate the disease, second only to ensuring that those with active TB complete treatment with appropriate drugs. Contacts of smear-positive TB patients are at high risk of developing TB and therefore must be screened for infection. If infected, these contacts should be offered complete treatment for latent infection. Performance reporting dates for FY 2002 – 2006 have been revised to accurately reflect the time lag in reporting data to CDC. In 2000, CDC adopted a new system for reporting on this measure. As a result, baseline data is substantially lower than that gathered under the previous system. Previous targets were set with a different data system which reflected a much higher baseline. The FY 2007 and FY 2008 targets have been revised in consideration of the new baseline data.

Through cooperative agreements with state and local health departments, CDC supports identifying and examining contacts of persons with active TB, as well as completing treatment for contacts who have latent TB infection. CDC is designing training for health department TB staff to improve their skills in this area. CDC is also working with the Health Resources and Services Administration (HRSA) and other federally funded programs serving groups at high risk for TB to facilitate testing and completion of treatment of latent TB infection.

VIRAL HEPATITIS

GOAL 12: REDUCE VIRAL HEPATITIS.			
Measure	**FY**	**Target**	**Result**
1. By 2010, reduce the number of new cases of hepatitis A to 2.25 new cases per 100,000 population [O]	*2008*	**2.4 new cases**	7/2009
	2007	2.5 new cases	7/2008
	2006	2.6 new cases	7/2007
	2005	2.6 new cases	1.9 (Exceeded)
	1997	Baseline	11.3
Data Source: The National Notifiable Diseases Surveillance System (NNDSS).			
Data Validation: NNDSS data are received from state health departments weekly and reviewed. Reports are checked and any pre-specified data are verified by contacting the appropriate state health department. All data are once again checked and verified with state health departments at the end of each calendar year.			
Cross Reference: HHS-1, PART, H.P. – 14.6			

Goal 12, Performance Measure 1:

CDC is on track to achieve the long-term target for hepatitis A. Overall, hepatitis A rates have declined dramatically; more than 78 percent since the last nationwide outbreak in 1995. The Healthy People 2010 target for reducing hepatitis A rates, 4.5 new cases per 100,000 population, was achieved in 2001. The rate in 2005, 1.9 new cases per 100,000 population, is the lowest rate recorded since surveillance for hepatitis A began in 1966. This precipitous decline in hepatitis A rates has coincided with the implementation of the Advisory Committee on Immunization Practices' (ACIP) recommendations for use of hepatitis A vaccine for the prevention and control of hepatitis A. In

particular, in 1999, the ACIP recommended routine vaccination of children living in 11 states which had consistently elevated hepatitis A rates during the previous decade (1987-1997) and suggested that vaccination be considered in another six states. In 2006, ACIP stated that elimination of indigenous HAV transmission in the U.S. was an attainable goal and recommended universal vaccination of all children at one year of age (e.g. 12 - 23 months) for HAV. Although increases in rates may still occur, it is expected that the downward trend in rates will continue with ongoing implementation of the ACIP vaccination strategy. Reporting dates for FY 2006, FY 2007 and FY 2008 have been extended as the data will be available in July of 2007. The FY 2006 result will be reported in July of 2007.

ZOONOTIC, VECTOR-BORNE, AND ENTERIC DISEASES

Efficiency Measure	FY	Target	Result
1. Enhance detection and control of foodborne outbreaks by increasing the number of foodborne isolates identified, fingerprinted, and electronically submitted to CDC's computerized national database networks with annual level funding. [E]	*2008*	**32,069 isolates**	12/2008
	2007	28,633 isolates	12/2007
	2006	24,866 isolates	27,618 (Exceeded)
	2005	21,471 isolates	22,684 (Exceeded)
	2004	17,876 isolates	18,729 (Exceeded)
	2003	Baseline	14,864
Data Source: PulseNet USA national databases established and maintained at CDC.			
Data Validation: Pattern submissions to PulseNet national databases are assessed and reviewed on a daily basis at CDC. Submitters to PulseNet databases are certified for competency before they are given access to the national databases. They are required to complete proficiency testing on an annual basis. Pattern and serotype statistics for all of the PulseNet databases are compiled, verified and reported on a quarterly and annual basis.			
Cross Reference: HHS-8, PART			

Efficiency Measure 1:

PulseNet, an early warning system for outbreaks of foodborne disease, is a national network of public health laboratories that performs DNA fingerprinting on bacteria that may be foodborne. This network identifies and labels each disease-causing organism by its fingerprint pattern and rapidly compares new patterns to those existing in the electronic database at CDC to identify related strains. The DNA fingerprinting can distinguish strains of disease-causing organisms such as *Escherichia coli* (*E. coli*), *Salmonella*, *Shigella*, and *Listeria*, allowing early detection of disease clusters.

Currently, databases are available for *E. coli*, *Salmonella*, *Listeria monocytogenes*, *Shigella*, and *Campylobacter*. CDC will increase the number of online submissions between 2006 and 2008 by increasing the number of individuals at the participating laboratories who are certified to electronically submit pulsed field gel electrophoresis (PFGE) patterns directly to the database.

GOAL 1: PROTECT AMERICANS FROM INFECTIOUS DISEASES – FOODBORNE ILLNESSES.			
Measure	**FY**	**Target**	**Result**
1. By 2010, reduce the incidence of infection with four key foodborne pathogens by 50%. [O] The 2010 targets by pathogen are: 12.30 *Campylobacter* 1.00 *Escherichia coli* O157:H7 0.25 *Listeria monocytogenes* 6.80 *Salmonella* species		*Campylobacter*	*Campylobacter*
	2008	**14.20**	5/2009
	2007	15.14	5/2008
	2006	16.10	5/2007
	2005	17.03	12.72 (Exceeded)
		Escherichia coli O157:H7	*Escherichia coli* O157:H7
	2008	**1.20**	5/2009
	2007	1.25	5/2008
	2006	1.30	5/2007
	2005	1.42	1.06 (Exceeded)
		Listeria monocytogenes	*Listeria monocytogenes*
	2008	**0.29**	5/2009
	2007	0.31	5/2008
	2006	0.33	5/2007
	2005	0.35	0.30 (Exceeded)

GOAL 1: PROTECT AMERICANS FROM INFECTIOUS DISEASES – FOODBORNE ILLNESSES.			
Measure	**FY**	**Target**	**Result**
		Salmonella species	*Salmonella* species
	2008	**7.90**	5/2009
	2007	8.39	5/2008
	2006	8.90	5/2007
	2005	9.45	14.55 (Unmet)
Data Source: FoodNet (The Foodborne Diseases Active Surveillance Network) Data.			
Data Validation: FoodNet data are transmitted, updated, and reviewed monthly. Incomplete data are reviewed with sites on a monthly basis, as are cross checks comparing local data with national data for data validity. Data are closed out and summarized on an annual cycle to produce preliminary reports, published in MMWR in spring of the following year, and a final report, later that year, once the updated population denominator data are available from the US Bureau of Census.			
Cross Reference: HHS-1, PART			

Goal 1, Performance Measure 1:

A summary of FoodNet data from 1996 to 2005 published on April 14, 2006, showed significant declines in rates of infection with *E. coli* O157, *Listeria*, and *Campylobacter*, suggesting the current efforts to reduce these diseases are largely on track toward the Healthy People 2010 objectives. Rates of infection with *Salmonella* have only modestly decreased. This may reflect increasing *Salmonella* contamination in poultry and challenges related to fresh produce. New interagency efforts in research and interventions to improve the effectiveness of food safety measures for *Salmonella* are now underway. CDC, in collaboration with FDA, began broad implementation of a national *Listeria* Action Plan to further reduce *Listeria* cases through efficient risk management, by empowering consumers and improving consumer safety.

PREPAREDNESS, DETECTION, AND CONTROL OF INFECTIOUS DISEASES

ANTIMICROBIAL RESISTANCE

GOAL 1: REDUCE THE SPREAD OF ANTIMICROBIAL RESISTANCE.			
Measure	**FY**	**Target**	**Result**
1. Reduce the number of courses of antibiotics for ear infections for children < 5 years to 57 courses per 100 children. [O]	*2006*	60 courses	11/2007
	2005	61 courses	47 (Exceeded)
	2004	62 courses	42 (Exceeded)
	2003	63 courses	53 (Exceeded)
2. Reduce the number of courses of antibiotics prescribed for a sole diagnosis of the common cold to 1,268 courses per 100,000 population. [O]	*2005*	1,917 courses	1,376 (Exceeded)
	2004	1,917 courses	1,007 (Exceeded)
	2003	2,017 courses	1,871 (Exceeded)
	2002	2,144 courses	1,913 (Exceeded)
3. Decrease the number of antibiotics prescribed for ear infections in children under 5 years of age per 100 children. [O]	*2008*	**57 courses**	11/2009
	2007	60 courses	11/2008
	2006	60 courses	11/2007
	2005	61 courses	50 (Exceeded)
Data Source: Measures 1 - 3: National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; NHAMCS, CDC, NCHS.			
Data Validation: A 10% quality control sample of survey records was independently keyed and coded.			
Cross Reference: Measure 1 - HHS-1, HP-14.18; Measure 2 - HHS-1, HP-14.19; Measure 3 - HHS-4, 5, HP-14.18, PART			

Goal 1, Performance Measures 1 and 3:

The number of courses of antibiotics given for ear infections to children under five years of age declined from 63 courses per 100 population in 2002 to 53 courses per 100 population in 2003 and decreased further to 42 per 100 population in 2004. Data from 2005 show a slight increase; however, the goal is still exceeded. Data show that antibiotic prescriptions for ear infections in children under five have declined considerably, compared to the 1997 baseline of 69 courses. Measure 1 will be retired after data are reported for FY 2006. Reporting dates for both measures 1 and 3 were extended to November in order to give the appropriate time to collect and report data accurately.

CDC's public health campaign "Get Smart: Know When Antibiotics Work" is the focus of this measure. The campaign involves an alliance of partners working to reduce inappropriate antibiotic use and reduce the spread of resistance to antibiotics. This national campaign includes a series of television, radio, and print public service announcements and comprehensive national, state, and local outreach. For example, in September 2003, CDC launched a national ad campaign created to promote appropriate antibiotics use knowledge among parents, which generated over 90 million audience impressions through television, print, and online media. Other current campaign activities include funding states to develop, implement, and evaluate local campaigns and evaluating and promoting a medical school curriculum on appropriate use of antibiotics. In addition, the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) now includes two measures on appropriate antibiotic use, promoted through the campaign.

In May 2004, the American Academy of Pediatrics and the American Academy of Family Physicians issued new guidelines for the management of ear infections. These guidelines present an option of observing selected children with ear infections without prescribing an antibiotic. CDC expects that as these guidelines are implemented prescribing antibiotics for ear infections will decline, accelerating movement toward achieving this goal.

Goal 1, Performance Measure 2:

Because the common cold is caused by a virus, antibiotic therapy is ineffective in treating these infections. Reducing the use of antibiotics in the treatment of the common cold remains one of the prime targets of CDC's antimicrobial resistance campaign. Success in exceeding this measure may reflect efforts by CDC and partners to promote appropriate antibiotic use in the community. Now that the data for FY 2005 have been reported, this measure is retired and will not be reflected in future performance detail.

MEDICAL ERRORS AND HEALTHCARE-ASSOCIATED INFECTIONS

GOAL 2: PROTECT AMERICANS FROM DEATH AND SERIOUS HARM CAUSED BY MEDICAL ERRORS AND PREVENTABLE COMPLICATIONS OF HEALTHCARE.			
Measure	**FY**	**Target**	**Result**
1. Reduce the rate of central line-associated bloodstream infections in adult ICU patients to 3.8. [O]	*2005*	3.8	3.0 (Exceeded)
	2004	3.8	3.5 (Exceeded)
	2003	3.8	4.0 (Unmet)
	2002	3.8	4.3 (Unmet)
2. Reduce the rate of central line associated bloodstream infections in medical/surgical ICU patients. [O]	*2008*	**3.54**	5/2009
	2007	3.54	5/2008
	2006	3.58	5/2007
	2005	3.62	3.5 (Exceeded)
	2004	3.66	3.6 (Met)
	2003	Baseline	3.7
Data Source: Before December 2004 - National Nosocomial Infections Surveillance (NNIS) system. After January 2005 - National Healthcare Safety Network (NHSN), which replaced NNIS.			
Data Validation: Extensive cross-field edit checks ensure the accuracy of the data, incomplete data cannot be transmitted. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.			
Cross Reference: Measure 1 - HHS-1, 5, 500-1; Measure 2 - HHS-1, 5, PART, 500-1			

Goal 2, Performance Measure 1:

The FY 2004 target for reducing central line-associated bloodstream infections was exceeded. Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 2, Performance Measure 2:

This measure uses data from combined medical/surgical intensive care units (ICUs) from hospitals not designated as major teaching facilities because they are the most prevalent unit reported in NNIS System and thus, most representative. From 2004 to 2005, the rate of central-line associated bloodstream infections in medical/surgical ICUs in non-major teaching hospitals decreased from 3.6 in 2004 to 3.5 in 2005.

GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES - LABORATORY RESPONSE.			
Measure	**FY**	**Target**	**Result**
1. Increase the percentage of Laboratory Response Network (LRN) labs with cumulative proficiency testing scores of 90% or better.	*2008*	**88% of labs**	12/2008
	2007	88% of labs	12/2007
	2006	84% of labs	88% (Exceeded)
	2005	80% of labs	88% (Exceeded)
	2004	Baseline	79%

GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES - LABORATORY RESPONSE.
Data Source: LRN labs report Proficiency Testing (PT) data to LRN secure website. Grading and summary of results are maintained on LRN website.
Data Validation: All of PT results are reviewed to meet grading criteria: 1. Proper identification of agent in the samples that contain the agent; 2. Ability of LRN labs to follow appropriate algorithm for obtaining results; 3. Ability to report with prescribed timelines. Automated grading tool is used to calculate PT passing rates. Designated individual review PT grading for errors.
Cross Reference: HHS-4, 5, PART, 500-4

Goal 3, Performance Measure 1:

The purpose of proficiency testing (PT) is to determine if LRN laboratories are continuously able to accurately identify the biological agents that may appear in naturally-occurring outbreaks or that may be used as agents of bioterrorism by using the instruments and protocols employed by the LRN. CDC provides a special PT program to each LRN laboratory that is, in turn, required to successfully participate. With each event, the PT program sends one or more select agents to each laboratory as pure cultures, genetic fragments, or substances embedded in a sample matrix mimicking an environmental powder or other sample. Laboratories are challenged to provide the correct genus and species answer using the established protocols within a limited and specified timeframe. The cumulative PT score for a year is calculated by averaging the scores from each quarterly PT and then at the end of the year, calculating a national average from the total number of sites that participate in the program.

The PT program has been in place since the LRN was initiated in 1999. At the onset of the program, very few state laboratories were able to rapidly and accurately identify biological and select agents. Because of the difficulty in identifying certain select agents and logistical issues, the success rate in 2003 was about 75 percent. In order to achieve a goal of a cumulative average of 90 percent or greater for all labs in the LRN, it is necessary to maintain constant communication regarding the standard operating plan regarding specimen analysis, to provide updates on protocols, to provide remediation and training to those laboratories that do not achieve the 95 percent goal, and to engage the Association of Public Health Laboratories (APHL) to assist in achieving this national goal. APHL has agreed to assume responsibility for monitoring its members. By the middle of FY 2005 the average was only 83 percent accuracy (88 percent by the end of FY 2005). Because of these averages, and because some organisms are very difficult to identify, the goal of reaching and maintaining 90 percent on a national scale is ambitious. While the goal of the LRN is to achieve a 100 percent accuracy rate, it is reasonable to assume that successful participation on a national scale would entail a success rate of 90 percent or greater accuracy.

HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

The Chronic Disease Prevention, Health Promotion, and Genomics program underwent OMB's Program Assessment Rating Tool (PART) review process in 2006 in preparation for the FY 2008 President's Budget. As a result, many performance measures have been retired and new goals and measures approved through the PART process have been added.

Efficiency Measure	FY	Target	Result
1. Increase the number of Web-based management information systems (MIS) resulting in savings of program staff time. [E]	*2006*	6	6 (Met)
	2005	6	7 (Met)
	2004	N/A	5
	2003	Baseline	4
2. Number of financial actions (such as project carryover funds requests from grantees and grantee project re-budgetings) that delay the implementation of grantee and partners' activities. (E)	*2008*	**419**	12/2008
	2007	433	12/2007
	2005	Baseline	466
Data Source: Measure 1 - All IT operations are centralized and MIS's are deployed only when activated by Center IT staff. They keep track of all active and developmental MIS's. Measure 2 - The Extramural Programs Management Information System (EPMIS), which is an internal system for tracking and managing all types of budget actions.			
Data Validation: Measure 1 - Center Information Systems Lead monitors active and developmental MIS's as part of normal duties. Measure 2 – EPMIS report will be run periodically and results authenticated by Division budget leads at monthly meetings with Center budget execution staff.			
Cross Reference: Measure 1 - HHS-5, 8; Measure 2 – HHS-5, 8, PART			

Efficiency Measure 1:

As project officers focus less on program administration, they spend more time providing program consulting, which increases the level of efficiency of a project officer. As such, this measure defines the number of management information systems within divisions that project officers use to provide more efficient program consulting to recipients. Currently, staff and recipients use the following six information systems to collect programmatic information: (1) Racial and Ethnic Approaches to Community Health Management Information System (REACH MIS), (2) Office of Smoking and Health's (OSH) National Tobacco Control Program Chronicle, (3) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Minimum Data Elements (MDE), (4) Division of Diabetes Translation Management Information System, (5) Prevention Research Center Information System and (6) Heart Disease and Stroke Management Information System. The NBCCEDP System for Technical Assistance Reporting (STAR) to report programmatic infrastructure data has been discontinued following an internal evaluation of the efficiency and usefulness of the data collection. Due to the development of a Center-wide efficiency measure during the PART process, this measure will be retired after data are reported for FY 2006.

Additionally, efficiency measures previously reported for Breast and Cervical Cancer prevention and Diabetes have been subsumed into the new Center-wide efficiency measure. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Efficiency Measure 2:

Approximately 85 percent of CDC's National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP) budget is spent on extramural funding of grantees and cooperative agreement partners, especially state health departments. These grantees and partners utilize funding to conduct interventions that directly impact the health of the nation. Any delay in receipt of funding results in reduction of the number or duration of the interventions, which, in turn, affects the health impact of our grantees' activities.

Based on recent implementation of a Project Officer training course, increased use of Management Information Systems to track these actions, and increased emphasis on technical assistance, the program will decrease these budget actions each year. Targets reflect a five percent decrease from baseline per year.

HEART DISEASE AND STROKE

GOAL 1: REDUCE DEATH AND DISABILITY DUE TO HEART DISEASE AND STROKE AND ELIMINATE DISPARITIES.			
Measure	**FY**	**Target**	**Result**
1. Reduce the proportion of heart disease and stroke deaths that occur before transport to emergency services in states funded for basic implementation programs. [O]	*2006*	Heart disease deaths 45%; Stroke deaths 43%	2/2009
	2005	Heart disease deaths 45%; Stroke deaths 43%	2/2008
	2004	Heart disease deaths 45%; Stroke deaths 43%	2/2007
	2003[1]	N/A	Heart disease deaths 49%; Stroke deaths 46%
	2002	N/A	Heart disease deaths 48%; Stroke deaths 45%
	2001	Baseline	Heart disease deaths 47%; Stroke deaths 44%
2. Reduce the prevalence of uncontrolled high blood pressure (>140/90) among patients with hypertension, especially among populations at high risk, in states that collaborate with community health centers. [O]	*2006*	50%	63% (Unmet)
	2005	50%	57% (Unmet)
	2004	50%	54% (Unmet)
	2003	N/A	60%
	2002	Baseline	60%
Data Source: CDC evaluates stroke registry capacity via annual state reports, deaths from heart disease and stroke via death certificate data from states, and uncontrolled high blood pressure data from HRSA and NCHS.			
Data Validation: Data is validated within HRSA and NCHS.			
Cross Reference: Measure 1 - HHS-1, 5,HP-12; Measure 2 - HHS-1, 5, 6, HP-12.1, 500-1			

[1]The heart disease measures for 2003 were inadvertently not included in the 2003 plan. Whereas 2003 dollars support the measures identified, 2003 targets were not provided.

Goal 1, Performance Measure 1:

Program activities are in place to achieve the performance measure of decreasing the proportion of heart disease and stroke pre-transport deaths. They include national and state-level health communication programs which cover symptom awareness and the need to call 911 for emergency transport. Intra and inter-state stroke networks, coalitions, and signs and symptoms campaigns have been developed. This measure will be retired after data are reported for FY 2006.

Goal 1, Performance Measure 2:

Program activities to achieve the performance measure of reducing the prevalence of uncontrolled high blood pressure among high-risk populations and patients with hypertension include collaborations between states and their Federally Qualified Community Health Centers, which provide healthcare to underserved, uninsured, and minority populations. To date, states have assisted health centers in conducting needs assessments, and providing hypertension training and educational assistance for providers related to national guidelines for hypertension care and prevention.

Community health centers continue to enhance and align their systems and practices with evidence-based recommendations to reduce heart disease and stroke risk factors. In FY 2006, HRSA merged the Cardiovascular Health Collaborative with the Diabetes Collaborative. Training and startup time led to a decrease in the desired effect. With the completion of the merger and training, it is anticipated that these results will improve. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

EARLY DETECTION OF BREAST AND CERVICAL CANCER

GOAL 2: INCREASE EARLY DETECTION OF BREAST AND CERVICAL CANCER BY BUILDING NATIONWIDE PROGRAMS IN BREAST AND CERVICAL CANCER PREVENTION, ESPECIALLY AMONG HIGH-RISK, UNDERSERVED WOMEN.			
Measure	**FY**	**Target**	**Result**
1. Excluding invasive cervical cancers diagnosed on an initial screen in NBCCEDP, lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older. [O]	*2006*	<14/100,000[1]	2/2008†
	2005	<14/100,000[1]	2/2007†
	2004	<15/100,000[1]	17/100,000 (Unmet)
	2003	<16/100,000[1]	15/100,000 (Exceeded)
	2002	<22/100,000	15/100,000 (Exceeded)
Data Source: Minimum Data Elements (MDEs).			
Data Validation: States, territories, and tribal organizations (NBCCEDP grantees) submit MDEs electronically twice a year (October 15 and April 15) to a data management contractor, who analyzes the data and submits analysis data to CDC in July and February. All data collected and submitted by NBCCEDP grantees have indicators to assess completeness. Data are also assessed against established clinical standards.			
Cross Reference: HHS-1, HP-3.4, 500-1,3			

[1] FY rate based on 3 years of data (see narrative text below).

Goal 2, Performance Measure 1:

Beginning in 2003, CDC moved to calculating this rate based on a rolling three-year timeframe rather than cumulative data (for instance, the FY 2003 rate reflects data for the time period 2001–2003). Using a three-year period ensures statistical stability in the rate.

Rates increased in FY 2004 and did not reach the target. CDC will continue to analyze these data and evaluate the measurements, policies and programs in place to determine why this target was not met. This measure will be retired after data are reported for FY 2006.

GOAL 3: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of women screened. [O] Breast: mammogram or Clinical Breast Examination (CBE) Cervical: Pap Smear	*2006*	Breast 401,000; Cervical 280,000	2/2008
	2005	Breast 401,000; Cervical 280,000	2/2007
	2004	Breast 381,682; Cervical 275,000	Breast 558,846 (Exceeded) Cervical 329,645 (Exceeded)
	2003	N/A	Breast 537,619; Cervical 304,407
	2002	N/A	Breast 394,146; Cervical 280,330
	2000	Baseline	Breast: 229,000; Cervical: 247,192
2. Increase the percentage of newly enrolled women who have not received a Pap test within the past 5 years. [O]	*2006*	Cervical 25%	2/2008
	2005	Cervical 25%	2/2007
	2004	Cervical 22.5%	22.1% (Unmet)
	2003	Cervical 22.5%	21.3% (Unmet)
	2002	N/A	22.2%
	2000	Baseline	Cervical 21.7%

GOAL 3: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Measure	**FY**	**Target**	**Result**
3. Increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening. [O] Breast: abnormal mammogram (suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete) and/or abnormal CBE Cervical: abnormal Pap includes high grade SIL, squamous cancer, or abnormal glandular cells	*2006*	Breast 87.5%; Cervical 64.5%	2/2008
	2005	Breast 87.5%; Cervical 64.5%	2/2007
	2004	Breast 86.5%; Cervical 64%	Breast 80.7% (Unmet) Cervical 62.6% (Unmet)
	2003	N/A	Breast 81.4%; Cervical 62.0%
	2002	N/A	Breast 82.8%; Cervical 63.0%
	2000	Baseline	Breast: 82.2%; Cervical: 61.2%
4. Increase the percentage of women with cancer who start treatment within 60 days of diagnosis. [O]	*2006*	Breast 95.5%; Cervical 92.5%	2/2008
	2005	Breast 95.5%; Cervical 92.5%	2/2007
	2004	Breast 95%; Cervical 92%	Breast 93.1% (Unmet) Cervical 87.6% (Unmet)
	2003	N/A	Breast 93.0% Cervical 91.9%
	2002	N/A	Breast 92.9%; Cervical 88.6%
	2000	Baseline	Breast: 94%; Cervical: 88%
5. Cervical: Increase the percentage of women with precancerous lesions who start treatment within 90 days of diagnosis (includes CIN (cervical intraepithelial neoplasia) II, CIN III, and CIS). [O]	*2006*	94.5%	2/2008
	2005	94.5%	2/2007
	2004	94%	90.4% (Unmet)
	2003	N/A	89.0%
	2002	N/A	90.3%
	2000	Baseline	92.4%
Data Source: MDE is used.			
Data Validation: Please refer to the previous performance table for a detailed explanation.			
Cross Reference: Measure 1 - HHS-1, 3, 5, 6,HP-3.3, 3.4, 3.10, 500-1,3; Measure 2 - HHS-1, 3, 5, 6,HP-3.4, PART, 500-1,3; Measure 3 - HHS-1, 3, 5, 6,HP-3.3, 3.4, 500-1,3; Measure 4 - HHS-1, 3, 5, 6,HP-3.3, 3.4, PART, 500-1,3; Measure 5 - HHS-1, 3, 5, 6,HP-3.4, 500-1,3			

Goal 3, Performance Measure 1:

CDC continues to increase the number of women screened through NBCCEDP by providing support for community outreach, education and recruitment. CDC also encourages programs to partner and/or collaborate with traditional and non-traditional partners to increase visibility, recruit eligible women, and increase provider networks. This measure will be retired after data are reported for FY 2006.

Goal 3, Performance Measure 2:

CDC encourages programs to reach underserved women for screening, including women who are rarely or never screened for cervical cancer. CDC defines "never or rarely screened" women as those who have not had a Pap test within the past five years. In FY 2004, 22.1 percent of newly enrolled women were rarely or never screened, just below our target of 22.5 percent and an increase from FY 2003. Because the measure relates only to newly enrolled women, projects must enroll new, rarely, and never screened women each year to meet this target. Therefore, it is a challenging target to achieve over time because programs must continually tap into communities to identify those who are rarely or never screened. This measure will be retired after data are reported for FY 2006.

Goal 3, Performance Measure 3:

In FY 2004, 80.7 percent of women with abnormal breast cancer screening results and 62.6 percent of women with abnormal cervical cancer screening results received a final diagnosis within 60 days. The FY 2004 figures represent a decrease in breast and increase in cervical timeliness of diagnostic follow-up over the FY 2003 figures. The comparatively lower percentage for cervical cancer screening reflects challenges facing CDC's programs, including delays in Pap results reporting from laboratories, long waiting periods for appointments for diagnostic services, and difficulties in tracking "hard to reach" women. Successful recall of women for diagnostic evaluation following unsuccessful earlier attempts will improve rates for completeness of follow-up, though negatively impacting timeliness. This measure will be retired after data are reported for FY 2006.

Goal 3, Performance Measure 4:

With the rapid expansion of screening services provided by the program (Goal 3, Measure 1), rates of timeliness to treatment fell short of targets. In FY 2004, 93.1 percent of women diagnosed with breast cancer and 87.6 percent of women diagnosed with invasive cervical cancer initiated treatment within 60 days. This is a slight improvement over FY 2003 for breast cancer and decline for cervical cancer. Rates and percentages are more stable when calculated from large numbers. Because the number of invasive cancer cases diagnosed through the program in FY 2004 is small (201 cases), trends based on annual measures for cervical cancer trends may be difficult to interpret. This measure will be retired after data are reported for FY 2006.

Goal 3, Performance Measure 5:

For women diagnosed with precancerous cervical lesions, CDC has set a target of ensuring the start of treatment within 90 days to 94 percent in 2004 and 94.5 percent in FY 2005. In 2000, the baseline for women diagnosed with precancerous cervical lesions that start treatment within 90 days was established at 92.5 percent. With the rapid expansion of screening services provided by the program (Goal 3, Measure 1), rates of timeliness to treatment fell short of targets. In FY 2004, the percentage of women with precancerous lesions who started treatment within 90 days of diagnosis was 90.4 percent, an increase from FY 2003. This measure will be retired after data are reported for FY 2006.

DIABETES PREVENTION AND CONTROL

GOAL 4: INCREASE THE CAPACITY OF STATE DIABETES CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF DIABETES AND ITS COMPLICATIONS AT THE COMMUNITY LEVEL.			
Measure	**FY**	**Target**	**Result**
1. For states receiving CDC funding for Diabetes Prevention and Control Programs (DPCPs), increase the percentage of persons with diabetes who receive annual eye and foot exams. [O]	*2006*	Eye 75%; Foot 70%	10/2007
	2005	Eye 75%; Foot 70%	Eye 60.6% (Unmet); Foot 66.0% (Unmet)
	2004	Eye 72%; Foot 62%	Eye 61.9% (Unmet); Foot 66.6% (Exceeded)
	2003	Eye 72%; Foot 62%	Eye 61.3% (Unmet); Foot 67.4% (Exceeded)
	2002	Eye 72%; Foot 62%	Eye 64.2% (Unmet); Foot 66.6% (Exceeded)
2. For states receiving CDC funding for DPCPs, increase the percentage of persons with diabetes who receive at least two A1c measures per year. [O]	*2006*	72.5%	10/2007
	2005	72.5%	64.3% (Unmet)
	2004	72.5%	68.8% (Unmet)
	2003	N/A	63.3%
	2002	Baseline	62.0%

GOAL 4: INCREASE THE CAPACITY OF STATE DIABETES CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF DIABETES AND ITS COMPLICATIONS AT THE COMMUNITY LEVEL.			
Measure	**FY**	**Target**	**Result**
3. Increase the number of DPCPs that promote health system approaches among those who are at high risk for developing diabetes (New initiative).	*2006*	5	10/2007
	2005	5	5 (Met)
	2004	5	5 (Met)
	2002	Baseline	0
Data Source: Data on receipt of annual eye and foot exams in persons with diabetes is collected through BRFSS.			
Data Validation: More than 30 validity and reliability studies attest to the quality and validity of data derived from the BRFSS. CDC verifies performance through quarterly state reports and periodic site visits. For efforts in American Indian/Alaska Native populations, data are verified via program reports and documentation of support. Also, CDC staff work closely with the Indian Health Service in validating data pertaining to American Indian/Alaskan Natives.			
Cross Reference: Measure 1 - HHS-1, 3, HP-5.13, 5.14, PART, 500-1, 3; Measure 2 - HHS-1, 3,HP-5.12, PART; Measure 3 - HHS-1, 6, HP-5.2, 500-1, 3			

Goal 4, Performance Measure 1:

In FY 2003, CDC began analyzing the Behavioral Risk Factor Surveillance System (BRFSS) data for this measure. Rather than focusing solely on basic implementation DPCPs, CDC now analyzes data from all the basic implementation and capacity building DPCPs participating in the BRFSS. CDC is now also using adjusted data rather than crude data.

Dilated eye exams leveled off in FY 2003 and dropped slightly in FY 2005. This may be due to a number of factors, including a possible increase in the use of fundus photography, a new technology that does not require dilation. For this reason, CDC is considering revising the BRFSS question which measures this objective. Also, recent studies have suggested that dilated eye exams performed every two years instead of annually are sufficient to prevent blindness from diabetic retinopathy in those without the condition. CDC continues to work with the state DPCPs to influence the preventive care practices of health systems and to inform providers and persons with diabetes about the importance of receiving annual eye exams to discover and treat diabetes-related eye disease in the earliest stages. This measure will be retired after data are reported for FY 2006.

Goal 4, Performance Measure 2:

This measure captures funded states progress in increasing A1c testing rates to the recommended level. The A1c test (short for hemoglobin A1c) measures blood glucose (sugar) control over the last three months. The suggested target for people with diabetes is seven percent; however, many people with diabetes have levels of nine percent or higher. Reducing blood glucose levels by just one percent among people with diabetes reduces their risk for microvascular complications (eye, kidney, and nerve disease) by 40 percent. This measure reflects the evolution of CDC's focus from process outputs to intermediate impact outcomes. There has been no clear trend in A1c testing over the last five years as rates have fluctuated slightly from year to year. This measure will be retired after data are reported for FY 2006.

Goal 4, Performance Measure 3:

CDC and its state-based DPCPs work with HRSA's Bureau of Primary Health Care and the Institute for Healthcare Improvement (IHI) to improve diabetes and pre-diabetes performance measures through improved care delivery systems, increased access, and decreased health disparities among medically underserved populations. The Diabetes Prevention Collaborative prototype involves five federally funded health centers and five DPCPs from across the country. The objectives of the Diabetes Prevention Collaborative are to identify the pre-diabetes population and those at highest risk for developing diabetes, and provide evidence-based lifestyle interventions to prevent and/or delay the progression to diabetes. Preliminary findings indicate that methods to identify the pre- diabetes population are effective. Lifestyle interventions are being tested for their effect on reaching population level goals of more than seven percent weight loss and more than 150 minutes of exercise per week.

To date, 2,387 individuals who have met the risk criteria for pre-diabetes have received an oral glucose tolerance test; more than half of these individuals (1,392) were found to have either pre-diabetes or previously undiagnosed diabetes. The collaborative shows that better outcomes in diabetes care and prevention are possible when the focus is on empowering individuals, improving the health care delivery system, and linking to communities where people live. This measure will be retired after data are reported for FY 2006.

TOBACCO USE PREVENTION

GOAL 5: REDUCE CIGARETTE SMOKING AMONG YOUTH.			
Measure	**FY**	**Target**	**Result**
1. Reduce the percentage of youth (grades 9-12) who smoke. [O]	*2005*	20.2	23.0% (Unmet)
	2003	26.5	21.9% (Exceeded)
	2001	34.2[1]	28.5% (Exceeded)
Data Source: CDC monitors cigarette use among youth and reports performance on a biennial basis using the national Youth Risk Behavior Survey (YRBS). Three additional surveys, the National Survey on Drug Use and Health (NSDUH), the Monitoring the Future (MTF) Survey, and the National Youth Tobacco Survey (NYTS), provide complementary data for examining trends and understanding youth-related tobacco issues. The NSDUH is conducted annually by SAMHSA; the MTF is conducted annually by the University of Michigan's Institute for Social Research, and funded by NIDA. The NYTS is conducted by CDC.			
Data Validation: Following procedures developed by CDC staff, the NYTS data collection and survey support contractor, Macro International Inc. (Macro) checked each student's responses to certain questionnaire items for consistency with other items. Upon receipt of the final cleaned 2004 NYTS data set from Macro, CDC staff conducted quality checks of data quality, survey design, and weighting.			
Cross Reference: Measure 1 - HHS-1, 7,HP-27.2, 500-1, 3			

[1] YRBSS (Youth Risk Behavior Surveillance System) data released in June 2004 indicated achievement of the FY 2003 target, and CDC revised the teen smoking projections.

Goal 5, Performance Measure 1:

Between 1991 and 1997, the prevalence of current cigarette use among youth (grades nine – twelve) increased from 27.5 percent to 36.4 percent. Since 1997, cigarette use among adolescents has declined substantially, and in 2003, this rate was at the lowest level since national surveys have been monitoring youth smoking. Factors that contributed to the decline included: 1) a 90 percent increase in the retail price of cigarettes from December 1997-May 2003, 2) increases in school-based efforts to prevent tobacco use, and 3) an increase in the proportion of young persons exposed through the mass media to smoking-prevention campaigns. All of these factors are components and/or recommendations of CDC's National Tobacco Control Program. However, the 2005 YRBS and other youth tobacco use surveys indicate that since 2003 this observed rate of decline may be reversing. From 2002 to 2004, factors preventing tobacco use (e.g., increasing the retail price of tobacco products, implementing smoking-prevention media campaigns, and funding for comprehensive state tobacco prevention and control programs) have declined. Meanwhile tobacco industry expenditures on tobacco advertising and promotion have been increasing, from $5.7 billion in 1997 to $15.2 billion in 2003. The emerging data underscore the need to fully implement evidence-based strategies that are effective in preventing youth tobacco use in order to continue progress toward meeting the Healthy People 2010 objective of reducing smoking among high school youth to 16 percent. Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

NUTRITION AND PHYSICAL ACTIVITY PROGRAMS TO PREVENT OBESITY AND OTHER CHRONIC DISEASES

GOAL 6: DECREASE LEVELS OF OBESITY, OR REDUCE THE RATE OF GROWTH OF OBESITY, IN COMMUNITIES THROUGH NUTRITION AND PHYSICAL ACTIVITY INTERVENTIONS.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of nutrition and physical activity interventions that are implemented and evaluated in funded states.	*2006*	25 interventions	12/2007
	2005	20 interventions	81 (Exceeded)
	2004	12 interventions	12 (Met)
	2002	Baseline	0 interventions
Data Source: CDC plans to collect and evaluate state data on nutrition and physical activity programs via annual state program reports, semi-annual progress monitoring reports, site visit reports, and a program evaluation database.			
Data Validation: Data is verified through submission of additional documentation, follow-up telephone calls, site visits, and other meetings.			
Cross Reference: Measure 1 - HHS-1, 5,HP-19, 22, 500-1, 3			

Goal 6, Performance Measure 1:

Since the inception of the program in FY 1999, funded states have been forming statewide coalitions, developing statewide action plans, and initiating and evaluating interventions. State partners include public health organizations, food producers and marketers, medical and education providers, parks and recreation, transportation, and urban planning agencies, local media, and communities. All states are developing, implementing and evaluating nutrition and physical activity health promotion interventions to address overweight and chronic disease in specific populations. At a minimum, these interventions are grounded in theory, have a defined purpose with clearly stated expected outcomes, have a defined methodology and strategy for implementation, and an evaluation component. In addition, these interventions are designed to:

- Establish supportive environments, making healthier lifestyle options (i.e., healthy eating and physical activity) in communities more readily accessible, affordable, comfortable, and safe.
- Establish policies and standards to support healthy eating and physical activity in communities.
- Establish programs in communities to increase physical activity and/or reduce caloric intake through healthy eating habits.
- Teach skills needed to make individual behavior changes related to nutrition, physical activity, and healthy weight, and designed to provide opportunities to practice these skills.

This measure will be retired after data are reported for FY 2006.

SCHOOL HEALTH PROGRAMS

GOAL 7: REDUCE THE PERCENTAGE OF HIV/AIDS-RELATED RISK BEHAVIORS AMONG SCHOOL-AGED YOUTH THROUGH DISSEMINATION OF HIV PREVENTION EDUCATION PROGRAMS.			
Measure	**FY**	**Target**	**Result**
1. Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90% or greater. [O]	*2005*	90% or more	87.9% (Unmet)
	2003	90% or more	87.9% (Unmet)
	2001	90% or more	89% (Unmet)
2. Increase the proportion of adolescents (grades 9–12) who abstain from sexual intercourse or use condoms if currently sexually active. [O]	*2005*	89%	87.5% (Unmet)
	2003	89%	87.5% (Unmet)
	2001	89%	86% (Unmet)
		African-American adolescents	African-American adolescents
	2005	87%	85.5% (Unmet)
	2003	87%	87% (Met)
	2001	87%	85% (Unmet)
		Hispanic adolescents	Hispanic adolescents
	2005	88%	85.3% (Unmet)
	2003	88%	84.4% (Unmet)
	2001	88%	84% (Unmet)
Data Source*: Data for both measures is collected through YBRSS. Data are released biennially.			
Data Validation: Validity and reliability studies of the YRBSS attest to the quality of the data. CDC conducts quality control checks and logical edit checks on each record.			
Cross Reference: Measure 1 - HHS-1, 2, 5, 7, HP-25, 500-1, 5; Measure 2 - HHS-1, 7, HP-25.11, 500-1, 5			

Goal 7, Performance Measure 1:

Data from the 2005 national YBRSS indicate that this measure has decreased since 1997 (92 percent) and that the small fluctuations in 1999 (91 percent) and in 2001 (89 percent) are not significantly different from time to time when considering the confidence intervals associated with sample data. CDC will continue to analyze these data and evaluate the policies, programs, and strategies in place to continuously improve the effectiveness of school-based

HIV/AIDS prevention education. This measure is being moved to a new youth and adolescent health goal developed in the PART process.

Goal 7, Performance Measure 2:

CDC continues to review, analyze, and discuss the possible reasons for not reaching the FY 2003 targets for all adolescents adolescents, in consultation with CDC's funded states, cities, and national nongovernmental organizations, and will make programmatic adjustments as needed to improve program effectiveness required to reach the stated targets. Data are released biennially. CDC now requires funded education agencies to complete program performance indicators. The performance indicators will enable CDC to better target technical assistance and assist states in determining priorities. This measure is being moved to a new youth and adolescent health goal developed in the PART process.

REACH 2010

GOAL 8: BY 2010, IMPROVE THE LIVES OF RACIAL AND ETHNIC POPULATIONS WHO SUFFER DISPROPORTIONATELY FROM THE BURDEN OF DISEASE AND DISABILITY, AND DEVELOP TOOLS AND STRATEGIES THAT WILL ENABLE THE NATION TO ELIMINATE THESE HEALTH DISPARITIES.			
Measure	**FY**	**Target**	**Result**
1. Develop national strategies (recommendations) to eliminate gaps in the six health priority areas based on the interventions and disseminate findings from the REACH 2010 Projects.	*2006*	Convene annual meeting of grantees to review and describe strategies developed to date. Disseminate promising strategies (recommendations) for the elimination of health disparities.	Yes (Met)
	2003	Baseline	Grantee meetings held in December 2003, June and October 2004; Dissemination of strategies began in July 2004
2. Collect qualitative and quantitative data in REACH 2010 communities to evaluate community capacity-building, intervention strategies, systems change, change among change agents, and change in risk/protective behaviors.	*2006*	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in 100% of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); 85% of REACH 2010 communities will collect and disseminate data (qualitative).	10/2007
	2005	Same as above	100%/85% (Met)
	2004	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in 100% of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); 60% of REACH 2010 communities will collect and disseminate data (qualitative).	100%/60% (Met)

GOAL 8: BY 2010, IMPROVE THE LIVES OF RACIAL AND ETHNIC POPULATIONS WHO SUFFER DISPROPORTIONATELY FROM THE BURDEN OF DISEASE AND DISABILITY, AND DEVELOP TOOLS AND STRATEGIES THAT WILL ENABLE THE NATION TO ELIMINATE THESE HEALTH DISPARITIES.
Data Source: REACH 2010 Risk Factor Survey.
Data Validation: Data is delivered to CDC every six months. Data is checked for missing values, outliers, unreasonable values, and illogical values by the contractor during the data collection process and at CDC after data have been delivered.
Cross Reference: Measure 1 - HHS-1, 3, HP-3.3, 3.4, 5, 12, 13, 14, 16.1, 500-1; Measure 2 - HHS-3, 4, 500-1, 3

Goal 8, Performance Measure 1:

CDC continues to work towards the development of national strategies (recommendations) for eliminating gaps in each of the six health priority areas based on the interventions and findings from the REACH 2010 Projects.

The dissemination of the most promising strategies and of lessons learned is critical to the overall effectiveness of this project. Preliminary measures have been taken to assess the dissemination strategies used by other programs at CDC. Partners that are critical in developing the dissemination plan include the funded communities, evaluation experts, external consultants, private partners, and other federal agencies. Grantee meetings were held in October 2005 and June 2006. In FY 2006, the grantee technical assistance and evaluation workshop attendees rotated in six workgroups to share and begin to synthesize results from their evidence-based and practice-based work. Dissemination work includes the REACH video Success Stories from Our Communities, which will serve as a mechanism to share lessons learned from the REACH program that can be applied by community leaders, public health and community services professionals, faith-based communities, and policy makers to reduce and eliminate health disparities that exist within their communities. In addition, special issues of three scientific journals focusing on the REACH 2010 findings were published: Journal of Health Care for the Poor and Underserved (May 2006), Preventing Chronic Disease (July 2006), and Health Promotion Practice (July 2006).

Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 8, Performance Measure 2:

The evaluation of REACH 2010 is of critical importance in determining the program's effectiveness in reducing health disparities. Working with its grantees and partners, CDC has developed an evaluation model that guides the collection of qualitative and quantitative data.

Between FY 2002 and FY 2005, the REACH 2010 Risk Factor Surveys were conducted in the 27 of the 40 REACH communities in which the health priority areas are breast and cervical cancer, cardiovascular disease, and diabetes. Communities that are focusing on cardiovascular disease and/or diabetes show that the proportion of Hispanics having cholesterol checks increased by 40 percent as compared to a small decline in the general U.S. population; the proportion of hypertensive American Indians on medication increased by ten percent compared to a six percent increase nationally; cigarette smoking among Asian American men decreased by more than 30 percent versus a six percent decline nationally, and the proportion of African Americans that have had their cholesterol checked increased compared to a small decline nationally.

The results of this data collection were disseminated to these 27 communities at the REACH 2010 Technical Assistant Workshop (October 3-5, 2005). The CD-ROMs which contain the combined four-year data and support documents were also distributed to grantees.

In addition, CDC has collected and disseminated qualitative data related to three stages of the REACH 2010 Evaluation Logic Model: (1) community capacity-building activities, (2) intervention strategies, and (3) systems change, and change among change agents. Information was collected through an internet-based data warehousing application called the REACH Information Network (REACH IN). REACH grantees use the system to document current resources, identify specific needs, and document efforts and outcomes. The system allows funded communities and CDC to monitor indicator outcomes related to specific health priority areas.

Eighty-five percent of REACH 2010 communities have collected qualitative data in the REACH IN system for dissemination. This measure will be retired after data are reported for FY 2006.

NEW GOALS AND MEASURES

CANCER

GOAL 1: REDUCE DEATH AND DISABILITY DUE TO CANCER .			
Measure	**FY**	**Target**	**Result**
1. Reduce the age-adjusted annual rate of breast cancer mortality per 100,000 female population. [O]	*2015*	21.3	2/2017
	1999	Baseline	26.6
2. Increase the percentage of women age 40+ who have had a mammogram within the previous two years. [O]	*2008*	**77%**	2/2010
	2004	Baseline	74.6%
3. Decrease the age-adjusted rate of invasive cervical cancer per 100,000 women ages 20+ screened through the NBCCEDP (excludes invasive cervical cancer diagnosed on the initial program screen). [O]	*2008*	**14**	2/2010
	2007	14	2/2009
	2004	Baseline	17
Data Source: Measure 1 - National Vital Statistics System, NCHS Measure 2 - Behavioral Risk Factor Surveillance System (BRFSS) Measure 3 – National Breast and Cervical Cancer Early Detection Program (NBBCEDP) Minimum Data Elements (MDE)			
Data Validation: Measure 1 -- Data from the NCHS, a nationally recognized public health information source, undergo statistical computation by the Data Analysis Support Team within CDC's Division of Cancer Prevention and Control to prepare measures based on definitions used within the cancer community. Measure 2 -- BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous quality checks. CDC also verifies performance through quarterly state reports and periodic site visits. Measure 3 – Grantees submit MDEs electronically to a data management contractor, who analyzes data and submits it to CDC. All data have indicators to assess completeness. Data are also assessed against established clinical standards.			
Cross Reference: Measure 1 – HHS 1, 6 ; HP-3.3; 500-3; PART; Measure 2 - HHS 1,6 ; HP-3-13; 500- 1,3; PART; Measure 3 – HHS-1, 6; HP-3.4, 500-1,3; PART			

Goal 1, Performance Measure 1:

Cancer is the second leading cause of death among all Americans, and breast cancer accounts for about 15 percent of cancer deaths among women. The program's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), developed in response to The National Breast and Cervical Cancer Mortality Prevention Act of 1990, contributes to the achievement of this mission by improving access to and the quality of breast and cervical cancer screening and early detection services nationwide.

Breast cancer mortality is declining steadily while incidence is increasing slightly. The decline in mortality is attributable in approximately equal parts to earlier detection through mammography screening and improved treatment. Consequently, continued increases in mammography should contribute to a continue decrease in mortality.

Goal 1, Performance Measure 2:

Timely mammography screening among women aged 40 years or older is the best available method to detect breast cancer in its earliest, most treatable stage, and could reduce breast cancer mortality by approximately 16 percent to 30 percent compared with women who are not screened.

Based on annual rates of increase in the 1990's, and the recent leveling-off of the increase in mammography use since the late 1990's, these projected increases would be challenging, yet achievable.

Goal 1, Performance Measure 3:

Cancer is the second leading cause of death among all Americans, and cervical cancer accounts for about 1.5 percent of cancer deaths among women. Sixty percent of the invasive cervical cancer diagnosed in this country is found among women who have never been screened, or have not been screened in the last five years.

Deaths from this disease occur disproportionately among women who are uninsured or underinsured. NBCCEDP helps low-income, uninsured, and under-served women gain access to lifesaving screening programs for the early detection of breast and cervical cancers and precancerous lesions. Pap tests funded by the NBCCEDP can find cervical cancer at an early stage when it is most curable or even prevent the disease if precancerous lesions found during the test are treated.

According to trend data from the National Cancer Institute's Surveillance, Epidemiology, and End Resuts Program (SEER) 1992-2002, the rate of invasive cervical cancer for all races combined was declining 2.8 percent per year; rates were significantly declining for white, black, Asian and Pacific Islander, American Indian/Alaska Native, and Hispanic women.

TOBACCO

GOAL 2: REDUCE DEATH AND DISABILITY AMONG ADULTS DUE TO TOBACCO USE.			
Measure	**FY**	**Target**	**Result**
1. Reduce the age-adjusted annual rate of trachea, bronchus, and lung cancer mortality per 100,000 population. [O]	*2010*	43.3	6/2012
	2003	Baseline	54.1
2. Reduce per capita cigarette consumption in the U.S. per adult age 18+. [O]	*2008*	**1,525**	6/2010
	2007	1,599	6/2009
	2004	Baseline	1770
Data Source: Measure 1 - National Vital Statistics System, NCHS Measure 2 - USDA, Economic Research Service, Tobacco Outlook Reports (TBS-259 Sep 2005, Table 2).			
Data Validation: Measures 1 - Data are validated by NCHS. Measure 2 -- The USDA Economic Research Service updates Tobacco Outlook Reports twice a year. Data quality checks ensure updated census population estimates are incorporated into per capita consumption estimates.			
Cross Reference: Measure 1 - HHS - 1, 6; HP 3-2; 500-3; PART; Measure 2 - HHS- 1, 6; HP 27-1; 500- 1,3; PART			

Goal 2, Performance Measure 1:

Cancer is the second leading cause of death among all Americans, and lung, trachea, and bronchus cancers account for 13 percent of all cancer diagnoses and 29 percent of all cancer deaths. Since 1964, the U.S. Surgeon General's reports on smoking and health have concluded that smoking is a primary cause of lung cancer, and since 1986 have concluded that exposure to secondhand smoke causes lung cancer in nonsmokers. Prior to the baseline year of 2003, mortality rates from lung cancer were decreasing steadily.

Goal 2, Performance Measure 2:

Since 1964, the U.S. Surgeon General's reports on smoking and health have concluded that smoking is a primary cause of lung cancer. National trends in per capita cigarette consumption are strongly correlated with national trends in lung cancer mortality rates and consumption trends are recommended as a primary surveillance indicator for lung cancer control efforts. Historical data shows a downward trend in this measure.

DIABETES

GOAL 3: PREVENT DIABETES AND ITS COMPLICATIONS.			
Measure	**FY**	**Target**	**Result**
1. Maintain the age-adjusted rate of incidence of End-Stage Renal Disease (ESRD) per 100,000 diabetic population at no higher than its current rate. [O]	*2010*	231.7	12/2011
	2002	Baseline	231.7
2. Increase the age-adjusted percentage of persons with diabetes age 18+ who receive an A1C test at least two times per year. [O]	*2008*	**73%**	12/2009
	2007	72%	12/2008
	2003-2004	Baseline	68.8%
Data Source: Measure 1 - US Renal Data System; Measure 2 - Behavioral Risk Factor Surveillance System (BRFSS)			
Data Validation: Measure 1 - The USRDS is under the administrative oversight of the National Institutes of Health and the Centers for Medicare and Medicaid Services, whose Steering Committee's responsibilities include data validation. Measure 2 -- BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous quality checks. CDC also verifies performance through quarterly state reports and periodic site visits.			
Cross Reference: Measure 1 - HHS-1, 6; 500-1,3; PART; Measure 2 - HHS-1, 6;HP 5-12; 500-1,3; PART			

Goal 3, Performance Measure 1:

End Stage Renal Disease (ESRD) is a complicated and disabling condition and one of the most expensive conditions for which the federal government provides financial coverage. Diabetes mellitus is presently the most common cause of ESRD in the U.S., accounting for approximately 45 percent to 50 percent of all cases of ESRD.

For decades, ESRD incidence was increasing. Since the late 1990's, the rates have declined. As those with diabetes live longer, the incidence of ESRD is likely to increase. Therefore, CDC aims to maintain the current baseline rate.

Goal 3, Performance Measure 2:

End Stage Renal Disease (ESRD) is a complicated and disabling condition and one of the most expensive conditions for which the federal government provides financial coverage. Glucose control is one important pathophysiologic factor in the genesis of ESRD. As A1C measurement is the best indicator of glucose control, the annual measure of A1C relates closely to the likelihood of achieving the long-term measure of controlling the rate of ESRD among persons with diabetes.

CDC aims to increase the age-adjusted proportion of persons with diabetes who receive two or more A1C tests by 1 percentage point every year.

HEART DISEASE AND STROKE

GOAL 4: REDUCE DEATH AND DISABILITY DUE TO HEART DISEASE AND STROKE .			
Measure	**FY**	**Target**	**Result**
1. Reduce the age-adjusted annual rate per 100,000 population of coronary heart-disease and stroke-related deaths. [O]	*2015*	CHD: 166 Stroke: 50	12/2017
	2002	Baseline	CHD: 187 Stroke: 61
2. Increase the age-adjusted proportion of persons age 18+ with high blood pressure who have it controlled (<140/90). [O]	*2007-2008*	**50%**	12/2010
	2005-2006	41%	12/2008
	2003-2004	40%	2/2007
	1999-2002	Baseline	32%
3. Maintain the age-adjusted proportion of persons age 20+ with high total cholesterol (>=240mg/dL) at no higher than its current rate. [O]	*2007-2008*	**17%**	12/2010
	2005-2006	17%	12/2008
	2003-2004	17%	2/2007
	1999-2002	Baseline	17%
Data Source: Measure 1 - National Vital Statistics System, NCHS Measure 2 - National Health and Nutrition Examination Survey (NHANES) Measure 3 - NHANES			
Data Validation: Measures 1 - 3 - Data are validated by NCHS.			
Cross Reference: Measure 1 – HHS- 1, 6; HP 12-1; 500-3; PART Measure 2 – HHS – 1, 6; HP 12-10; 500-1, 3; PART Measure 3 – HHS-1, 6 ; HP 12-14; 500-1,3; PART			

Goal 4, Performance Measure 1:

Currently, Coronary Heart Disease (CHD) is the single largest killer of Americans, causing one of every five deaths in the U.S. in 2003. It is estimated that 700,000 Americans will have a new coronary attack and about 500,000 will have a recurrent attack. Stroke ranks number three among all causes of death, accounting for about one of every 15 deaths in the U.S. in 2003. Each year about 700,000 people experience a new or recurrent stroke.

CHD death rates have been decreasing steadily since 1995. Stroke rates have been fairly stable since 1998.

Goal 4, Performance Measure 2:

Hypertension affects approximately 65 million adults (nearly one in three) in the U.S. and is the most common primary diagnosis in America. The relationship between blood pressure and the risk of CVD events is consistent and independent of other factors. The higher the blood pressure, the greater is the chance of heart attack, heart failure,

stroke, and kidney disease. About 69 percent of people who have a first heart attack, 77 percent who have a first stroke, and 74 percent who have congestive heart failure have hypertension.

Prior to 2000, data for this measure was collected sporadically. In order to reach the target, high blood pressure control should increase by approximately 4.5 percentage points per year. Annual targets reflect that increase.

Goal 4, Performance Measure 3:

Approximately 38 million American adults have blood cholesterol levels of 240 mg/dL or higher, which is considered high risk. Lowering cholesterol can reduce the risk for developing heart disease, including heart attacks, and, among those with heart disease, the need for heart bypass surgery or angioplasty. Recent studies show that high levels of LDL ("bad" cholesterol) and triglycerides increase the risk of stroke in people with previous coronary heart disease, ischemic stroke or transient ischemic attacks (TIAs). Low levels of HDL ("good" cholesterol) may also raise stroke risk.

Although the objective of 17 percent was reached during 1999-2002, the estimate is expected to increase with the emerging epidemic of obesity. The annual targets reflect maintenance at the current level.

NUTRITION AND PHYSICAL ACTIVITY

GOAL 5: REDUCE THE RATE OF GROWTH OF OBESITY THROUGH NUTRITION AND PHYSICAL ACTIVITY INTERVENTIONS.			
Measure	**FY**	**Target**	**Result**
1. Reduce the age-adjusted percentage of adults age 18+ who engage in no leisure-time physical activity. [O]	*2014*	21.5%	12/2015
	2004	Baseline	24.36%
2. Slow the estimated average age-adjusted annual rate of increase in obesity rates among adults age 18+. [O]	*2010-2014*	+0.16 average increase per year	12/2015
	2002-2004	Baseline	+0.64 average increase per year
Data Source: Measures 1 and 2 - Behavioral Risk Factor Surveillance System (BRFSS)			
Data Validation: Measures 1 and 2 – BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous data quality checks. CDC also verifies performance through quarterly state reports and periodic site visits.			
Cross Reference: Measure 1 - HHS- 1, 6;HP 22-1; 500- 1,3; PART Measure 2 - HHS- 1, 6 ; HP 19-2; 500- 1, 3; PART			

Goal 5, Performance Measure 1:

Major causes of morbidity and mortality in the U.S. are related to physical inactivity and poor diet. In particular, cardiovascular disease, type 2 diabetes, hypertension, and certain cancers are linked to poor diet and a sedentary lifestyle.

There has been an absolute decline from 29 percent to 24 percent in the past ten years. Rate of decrease is expected to lessen over the next ten years.

Goal 5, Performance Measure 2:

About 60 million adults, or 30 percent of the adult population, are now obese. Obesity is related to two-thirds of diabetes cases and of heart disease cases, 20 percent of cancers in women and 15 percent of cancers in men. Additionally, it causes or exacerbates many other serious chronic diseases and conditions, including hypertension and stroke.

Rates of obesity have been increasing at the rate of approximately 0.64 percentage points per year during the years 2002 through 2004. CDC aims to slow the rate of growth in obesity rates.

YOUTH AND ADOLESCENT HEALTH

GOAL 6: IMPROVE YOUTH AND ADOLESCENT HEALTH BY HELPING COMMUNITIES CREATE AND ENVIRONMENT THAT FOSTERS A CULTURE OF WELLNESS AND ENCOURAGES HEALTHY CHOICES .			
Measure	**FY**	**Target**	**Result**
1. Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90% or greater. [O]	*2009*	90%	6/2010
	2007	90%	6/2008
	2005	Baseline	87.9%
2. Increase the proportion of adolescents (grades 9-12) who abstain from sexual intercourse or use condoms if currently sexually active. [O]	*2009*	89%	6/2010
	2007	89%	6/2008
	2005	Baseline	87.5%
3. Reduce the proportion of children aged 3 to 11 who are exposed to second-hand smoke. [O]	*2008*	45%	12/2010
	2007	45%	12/2009
	2001-2002	Baseline	55%
4. Percentage of youth (grades 9-12) who were active for at least 60 minutes per day for at least five of the preceding seven days. [O]	*2009*	35.8%	6/2010
	2007	35.8%	6/2008
	2005	Baseline	35.8%
Data Source: Measure 1 - Youth Risk Behavior Surveillance System (YBRSS) Measure 2 - YBRSS Measure 3 – NHANES Measure 4 - YBRSS			
Data Validation: Measures 1, 2 and 4: Validity and reliability studies of YRBSS attest to the quality of the data. CDC conducts quality control checks and logical edit checks on each record. Measure 3 – Data are validated by NCHS.			
Cross Reference: Measure 1 - HHS - 1 ; HP 7-2; 500- 1,3, 5, 6 Measure 2 – HHS - 1; HP 25-11; 500 -1, 3, 5, 6 Measure 3 – HHS -1, 7 ; HP 27-10; 500-1, 3; PART Measure 4 – HHS-1, 500-1,3; PART			

Goal 6, Performance Measure 1:

In 2004, an estimated 7,761 young people were living with AIDS, a 42 percent increase since 2000, and an estimated 3,867 young people received a diagnosis of HIV/AIDS, representing about 12 percent of the persons given a diagnosis during that year. Young men who have sex with men, especially those of minority races or ethnicities, were at high risk for HIV infection.

Goal 6, Performance Measure 2:

Each year there are approximately 19 million new STD infections in the U.S. and almost half of them are among youth ages 15 to 24. Thirty-four percent of young women – approximately 820,000 each year – become pregnant at least once before the age of 20. Data from the 2005 Youth Risk Behavior Survey (YRBS) show that 47 percent of high school students had had sexual intercourse, Fourteen percent of high school students had four or more sex partners during their lifetime, and 37 percent of sexually active high school students did not use a condom at last intercourse. STDs (including HIV) among youth result in substantial economic burden to our society. The total estimated burden of the nine million new cases of STDs that occurred among 15 to 24-year-olds in 2000 was $6.5 billion (in year 2000 dollars).

Goal 6, Performance Measure 3:

Cancer is the second leading cause of death among all Americans, and lung, trachea, and bronchus cancers account for 13 percent of all cancer diagnoses and 29 percent of all cancer deaths. Secondhand smoke, also known as environmental tobacco smoke (ETS), has been determined to be a known human carcinogen. Persistent exposure to ETS is associated with an increased risk for lung cancer. Since 1986, the U.S. Surgeon General's reports have concluded that exposure to secondhand smoke causes lung cancer in nonsmokers.

The program provides national leadership for a comprehensive, broad-based approach to reducing tobacco use which involves: preventing young people from starting to smoke; eliminating exposure to secondhand smoke; promoting quitting; and, identifying and eliminating disparities in tobacco use among population groups. It also develops health communication campaigns aimed at informing the public about the health risks associated with environmental tobacco smoke and reducing disparities in these exposures.

Prior to the baseline time period, this measure was declining steadily, with significant progress between the end of NHANES III (1988-1994) and the most recent NHANES (1999-2002).

Goal 6, Performance Measure 4:

Increased physical activity—whether through structured (e.g., organized recreation or sports) or unstructured (e.g., recess, free play) opportunities—helps reduce the risk of chronic diseases and prevent excess weight gain among children and adolescents. Physical activity is a critical component of obesity prevention efforts, as those adolescents who are already overweight are at an increased risk --70 percent chance--of becoming overweight and obese adults. Chronic diseases and obesity in adulthood are even more likely if overweight existed in adolescence, thereby increasing the likelihood of adults suffering from multiple comorbidities, such as heart disease, type 2 diabetes, and certain types of cancer.

Prior to the baseline year, this data was not collected by the YRBSS. The guideline for this measure was developed and published in the baseline year.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

The Birth Defects and Developmental Disabilities program underwent OMB's Program Assessment Rating Tool (PART) process in 2006 in preparation for the FY 2008 President's Budget. As a result, several of the performance budget measures have been changed or retired, while new measures approved through the PART process have been added.

Efficiency Measure	FY	Target	Result
1. Establish an ongoing data management center for developmental disabilities monitoring and research sites, resulting in savings of program staff time. [E]	*2005*	Establish data center	Yes (Met)
2. Increase the number of autism cases included in the data coordinating center, resulting in savings of program and staff time and expediting efforts to understand the prevalence and find the causes of autism. [E]	*2006*	250	12/2007
3. Increase the percent of competitive (new) cooperative agreements/grants that are processed in less than or equal to 176 days (excluding extramural research). [E]	*2008*	**91%**	2/2009
	2007	82%	2/2008
	2006	73%	2/2007
	2005	Baseline	64%
Data Source: Measures 1 and 2 - Data Coordinating Center for Autism and Developmental Disabilities Surveillance and Epidemiologic Research; Measure 3 - National Center on Birth Defects and Developmental Disabilities Extramural Program Management Information System (EPMIS).			
Data Validation: Measures 1 and 2 - Once software is operational and collaborative autism research study is underway, staff will be able to retrieve and report the number of autism cases entered into database. Measure 3 - Staff will use current software to track the number of days from delivery of funding package to actual award of resources to grantee.			
Cross Reference: Measure 1 - HHS-8, HP-16.14, 500-1; Measure 2 - HHS-8, HP-16.14, 500-1; Measure 3 - HHS-16, HP-16.14, 500-1, PART			

Efficiency Measure 1:

CDC supports Centers for Autism and Developmental Disabilities Research and Epidemiology in six states. These Centers (including CDC's own model tracking program in Atlanta) track autism and other developmental disabilities and conduct public health research into the causes of autism. These efforts are essential for CDC to fulfill its Congressional mandate to collect, analyze, and disseminate autism data. The successful establishment of an ongoing data management center for these sites has resulted in significant time savings. Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

Efficiency Measure 2:

Following the establishment of a data management center for developmental disabilities, CDC will be able to track progress in this area by focusing on increasing the number of autism cases included in the Data Coordinating Center, thus saving program and staff time and expediting efforts to understand the prevalence and causes of autism. This measure will be retired after data are reported for FY 2006.

Efficiency Measure 3:

In FY 2005, CDC spent over 60 percent of its budget on cooperative agreements and grants. Because awarding of cooperative agreements and grants involves a 25 step process, executing the award process efficiently and accurately is of critical importance. Increased accuracy and timeliness of the awarding process will allow grantees to optimize use of funds and increase the probability of fully executed awards during the project period. In addition, the program will save work hours expensed through repetitive processes. Ultimately, the goal of the expeditious disbursement of funds will promote implementation of public health interventions designed to improve the nation's health. In FY 2005 (baseline), 64 percent of new competitive cooperative agreements/grants were processed within the target of 176 days.

GOAL 1: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.			
Measure	**FY**	**Target**	**Result**
1. Decrease the percentage of women who report any alcohol consumption during pregnancy. [O]	*2006*	8.0%	12/2008
	2005	8.5%	12/2007
	2004	10.0%	10.8% (Unmet)
	2003	11.5%	10.6 % (Exceeded)
	1999	Baseline	12.8%
2. Reduce by 1% per year the number of children born with spina bifida and anencephaly through promotion of folic acid consumption by women of reproductive age. [O]	*2006*	4% reduction	12/2009
	2005	3% reduction	12/2008
	2004	2% reduction	12/2007
	2003	1% reduction	2,021 (Unmet)
	2000	Baseline	1,932
3. Increase the number of U.S. births covered by birth defects monitoring programs, which use these data to plan services for children and evaluate prevention strategies.	*2006*	2,900,000	2,860,134 (Unmet)
	2005	2,800,000	2,803,301 (Exceeded)
	2004	2,700,000	2,644,925 (Unmet)
	2003	2,600,000	2,609,477 (Exceeded)
4. Increase the sensitivity of birth defects and developmental disabilities monitoring data. [O]	*2008*	**Birth Defects- Improve by 1% /Developmental Disabilities- Data analyses and preliminary results**	12/2008
	2007	Birth Defects- Establish Baseline/Developmental Disabilities- Enroll remaining eligible sample	12/2007
	2006	Developmental Disabilities- Enroll 40-50% of eligible sample	Yes (Met)
	2005	Developmental Disabilities- Initiate validation study	Yes (Met)
5. Identify and evaluate the role of at least five new factors for birth defects and developmental disabilities.	*2008*	**Publish findings on maternal medications**	12/2008
	2007	Publish findings on alcohol, caffeine use, and nutrition	12/2007
	2006	Finalize research agenda for birth defects and publish findings on smoking, obesity, and other exposures with high potential impact	Yes (Met)
	2005	Establish large statistically powerful sample for birth defects research	Yes (Met)
6. Reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly by reducing the birth prevalence of these conditions among Hispanics. [O]	*2008*	**4.8**	12/2011
	2007	4.9	12/2010
	2006	5.0	12/2009
	2005	5.1	12/2008
	2004	5.3	12/2007
	2003	5.4	6.4/10,000 (Unmet)
	2000	Baseline	6.2/10,000

GOAL 1: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.			
Measure	**FY**	**Target**	**Result**
7. Increase the percentage of health providers who screen women of childbearing age for risk of an alcohol-exposed pregnancy and provide appropriate, evidence-based interventions for those at risk. [O]	*2008*	**Implement ongoing provider education programs and establish baseline rates of provider-based screening and intervention.**	12/2008
	2007	Assess the screening and intervention practices of nationally representative samples of provider groups.	12/2007
	2006	Develop and disseminate screening and intervention tools for health care providers serving women of childbearing age.	Yes (Met)
	2005	Complete randomized control trial determining effectiveness of provider-based interventions for preconceptional women who are at risk for an alcohol-exposed pregnancy.	Yes (Met)
	2004	Publish targeted recommendations for provider-based screening and intervention.	Yes (Met)
	2003	Publish study assessing feasibility of provider-based interventions targeting women at high risk for alcohol-exposed pregnancy.	Yes (Met)
Data Source: Measure 1 **-** Data are from CDC's Behavioral Risk Factor Surveillance System (BRFSS). Measure 2 - Data are from the National Birth Defects Prevention Network (NBDPN). Measure 3 - Data are from the Developmental Disabilities Data Coordinating Center. Measure 4 – Metropolitan Atlanta Congenital Defects Program (MACDP) and the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP). Measures 5 and 6 – NBDPN. Measure 7 – Data are from Project CHOICES, a CDC-funded randomized control trial regarding provider-based interventions for preconceptional women who are at risk for an alcohol-exposed pregnancy.			
Data Validation: Measure 1 - BRFSS data are collected each month and from every state, D.C., and 3 U.S. territories through a random-digit-dialed telephone survey. In addition to providing training and technical assistance, CDC staff produce monthly and annual quality assurance reports. Measure 2 - Prevalence data obtained from eight population-based surveillance systems in the NBDPN. Due to ongoing data collection with more recent years less likely to be complete, reporting lags are utilized to ensure more complete data. Denominator data are based on the number of live births reported by CDC's National Center for Health Statistics. Measure 3 - As part of the NBDPN, all data are updated annually. In addition, states conduct three validation checks in conjunction with CDC prior to publication of the identified data. Measure 4 – Data from the CDC-based model birth defects surveillance system are updated annually. Measure 5 – Publications are made possible as a result of analyses of NBDPN pooled data sets. Measure 6 – Data from NBDPN are used to measure rates of spina bifida and anencephaly among Hispanics. Measure 7 – Results of the randomized control trial (2005 target) published in a peer-reviewed journal.			
Cross Reference: Measure 1 - HHS-1, HP-16.17, 500-1; Measure 2 - HHS-5, HP-16.15-16, 500-1; Measure 3 - HHS-4, HP-16.15, 500-1; Measure 4 – HHS-4, HP-16.1f, HP-16.14, 500-1, PART; Measure 5 – HHS-4, HP 16.1f, HP-16.14, 500-3, PART; Measure 6 – HHS-1, HHS-3, HP-16.15, HP-16.16, 500-1, PART; Measure 7 – HHS-1.4, HHS-3, HP-16.17, HP-16.18, 500-1, PART			

Goal 1, Performance Measure 1:

CDC funds programs designed to build statewide capacity in Fetal Alcohol Syndrome (FAS) prevention and monitoring; a collaborative research consortium for identifying, developing, and evaluating effective strategies for intervening with children and/or adolescents with FAS and related conditions; research programs to identify and test new FAS prevention and management methods; regional training centers to increase health care providers' knowledge about how to present FAS; and education materials for parents, educators and social service providers about accessing appropriate diagnostic and treatment services for affected children and their families. In addition, CDC provides support to all 50 states to monitor alcohol consumption levels, and support targeted outreach to Cherokee nation. CDC met and exceeded the FY 2003 target, with 10.6 percent of women reporting alcohol consumption during pregnancy. However, in FY 2004, the target was not met. CDC is implementing a recently- proven successful intervention to reach high-risk women. CDC anticipates that this intervention will contribute to reducing rates of alcohol consumption during pregnancy. This measure will be retired after data are reported for FY 2006.

Goal 1, Performance Measure 2:

Fortification of the food supply with folic acid (a B vitamin) has allowed major reductions in the rates of serious neural tube birth defects of the spine (spina bifida) and brain (anencephaly). However, more reductions are possible if all women of reproductive age consume adequate amounts of folic acid before, and during, pregnancy. CDC published data documenting the effectiveness of folic acid fortification in preventing spina bifida and anencephaly. Data from birth defects monitoring programs showed that, as a result of fortification, approximately 1,000 more babies are born without these defects each year. Data show the number of children born with these defects were 1,709 in 2002, an 11.5 percent decrease from the 2000 baseline of 1,932. Data from 2003, however, show the number of cases increasing to 2,021, leaving this target unmet for this year. While an increase from one year to the next does not necessarily mean a reversal in the trend of declining rates, CDC has published an analysis documenting declining levels of blood folate among women of childbearing age. It is unclear of the exact reason for the decline (however, popularity of low carbohydrate diets may contribute) but decreased consumption of folic acid would negatively affect rates of folic acid-preventable birth defects. This measure will be retired after data are reported for FY 2006.

Goal 1, Performance Measure 3:

Increasing the number of births covered by monitoring programs increases the quality of the data, which can then be used more effectively to draw programmatic and scientific conclusions. Establishing prevalence rates will help CDC to more effectively allocate resources, develop prevention strategies, and evaluate the effectiveness of prevention efforts. Similarly, the ability to detect regional differences in prevalence rates will give CDC important information about risk factors and causes of birth defects. CDC publishes data from the monitoring programs in its annual congenital malformations report. In FY 2006, CDC worked to increase the number of births covered by birth defects monitoring programs by guiding and funding states to build and strengthen birth defects surveillance systems. While the number of births did increase in FY 2006, the target was not met. CDC will continue to fund state birth defects surveillance programs which support the NBDPN, a collaboration of individuals working at the local, state and national levels in birth defects surveillance, research and prevention. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 1, Performance Measure 4:

This measure was developed through the 2006 PART process.

Because the birth defects system is more mature and able to be assessed numerically, investments in the developmental disabilities systems are needed to measure the same level (a study was developed in 2004 and initiated in 2005). However, the model for the birth defects and developmental disabilities surveillance systems is based on the same methodology. CDC projects baseline data will be available by the end of 2007 for Birth Defects and in 2009 for Developmental Disabilities. For birth defects, the target percentage is a measure of sensitivity. For developmental disabilities, the measure is initially based on establishing the baseline probability that a true developmental disability is identified by the program's model system.

Goal 1, Performance Measure 5:

This measure was developed through the 2006 PART process.

Understanding the role of modifiable risk and preventive factors in the etiology of birth defects and developmental disabilities provides an important opportunity for prevention. As prior investments in the research infrastructure for birth defects is more mature, initial efforts for annual performance measures focus on publication of research findings from this system. Meanwhile, the infrastructure for research on autism and other developmental disabilities research is being established. This research infrastructure follows the same model as birth defects but is in the early stages of development, with initial publication of findings expected in 2012.

Goal 1, Performance Measure 6:

This measure was developed through the 2006 PART process.

Pregnancies and births affected by spina bifida and anencephaly have profound physical, emotional, and financial effects on families and communities. Since food fortification began in 1998, thousands of babies are being born in the U.S. without these serious birth defects. However, analyses by racial and ethnic groups found that while fortification lowered rates significantly among all racial and ethnic groups, a disparity with respect to Hispanics has persisted. CDC is currently focusing on developing and implementing evidence-based strategies to reduce the occurrence of these birth defects among Hispanics. Targets are based on the concept of diminishing returns, the understanding that preventing the earlier cases was easier than preventing the latter cases. For example, in 1996 - 2000, rates declined by 36 percent. As it became increasingly difficult to prevent cases with existing strategies, more intensive efforts were required to achieve the same level of reductions. Thus, for the next five year period (2001-2005), targets were set based on a proposed 18 percent decline in rates (half of 36 percent). Similarly, for the subsequent five years (2006-2010), CDC set targets based on a proposed decline of an additional 9 percent (one-half

of 18 percent) from 2005. Unfortunately, data for 2003 reveal an increase in the rate of these birth defects among the Hispanic population. These data further underscore the importance of targeted efforts to address the high rates among Hispanics. CDC's two priority activities in this area are developing and disseminating targeted campaign materials and working with partners to explore the addition of folic acid to corn flour products.

Goal 1, Performance Measure 7:

This measure was developed through the 2006 PART process.

Implementing intervention strategies to reduce alcohol consumption during pregnancy is an important component of reducing the occurrence of alcohol-related birth defects and developmental disabilities, including Fetal Alcohol Syndrome. Research shows that 1) provider-based screening of women of childbearing age at risk of having an alcohol-exposed pregnancy, and 2) provider-based interventions for women at risk are effective strategies for reducing alcohol-exposed pregnancies. CDC has begun to translate research findings through the development and publication of targeted recommendations on provider-based screening and interventions for women of childbearing age. CDC has developed a quick-reference clinician tool to facilitate screening and interventions among providers. As of December, 2006, over 4,000 toolkits have been disseminated. Through education about and implementation of this tool, CDC aims to improve the percentage of health care providers who screen women of childbearing age for risk of alcohol-exposed pregnancy and provide appropriate interventions for those at risk.

GOAL 2: IMPROVE THE HEALTH AND QUALITY OF LIFE OF AMERICANS WITH DISABILITIES.			
Measure	**FY**	**Target**	**Result**
1. By 2010, decrease to 10% the percentage of newborns that screen positive for hearing loss but are lost to follow-up. [O]	*2006*	22%	12/2008
	2005	25%	12/2007
	2004	30%	23% (Exceeded)
	2003	35%	31% (Exceeded)
	2002	Baseline	36.6%
2. Decrease the overall health disparity experienced by people with disability by increasing the number of states that implement a health promotion program to improve the health and quality of life for persons with disabilities.	*2006*	20	29 (Exceeded)
	2005	8	27 (Exceeded)
	2004	7	25 (Exceeded)
	2003	6	17 (Exceeded)
3. Increase the number of people with blood disorders who participate in the monitoring system by 10%. [O]	*2008*	**18,948**	12/2008
	2007	18,590	12/2007
	2006	18,232	19,889 (Exceeded)
	2005	Baseline	17,874
4. Identify an effective public health intervention to ameliorate the effects of poverty on the health and well-being of children. [O]	*2008*	**Data collection and analysis for age 3 year**	12/2008
	2007	Data collection and analysis for age 2 year	12/2007
	2006	Data collection and analysis for age 1 year	Yes (Met)
	2005	Data collection and analysis for age 6 months	Yes (Met)
	2004	Baseline data collection	Yes (Met)
	2002	Initiate main study	Yes (Met)
5. Ensure that 95% of all infants are screened for hearing loss by 1 month of age. [O]	*2008*	**93%**	12/2010
	2007	92%	12/2009
	2006	91%	12/2008
	2005	90%	12/2007
	2004	89%	92% (Exceeded)
	2003	Baseline	88%

GOAL 2: IMPROVE THE HEALTH AND QUALITY OF LIFE OF AMERICANS WITH DISABILITIES.			
Measure	**FY**	**Target**	**Result**
6. Increase the mean lifespan of patients with DBMD and carriers by 10% as measured by the Muscular Dystrophy Surveillance, Tracking and Research Network. [O]	*2008*	**Report on the impact of clinic use on morbidity and mortality in DBMD using MD STARnet data**	12/2008
	2007	Identify and report on (1) the incidence and prevalence of DBMD in the United States based on MD STARnet data (2) early signs and symptoms of DBMD based on MD STARnet and (3)cost of health care of people with DBMD.	12/2007
	2006	Conduct data analysis on MD STARnet data collected in the 4 current sites and include one additional state.	Yes (Met)
	2005	Analyze preliminary mortality data associated with DBMD from MD STARnet	Yes (Met)
	2004	Establish a health surveillance system for DBMD in 4 states	Yes (Met)
Data Source: Measures 1 and 5 **-** Data are from the University of Montana**,** Directors of Speech and Hearing Programs for State Health and Welfare Agencies (DSHPSHWA).). Measure 2 – Data are from the University of Montana Rural Institute: Center for Excellence in Disability Education, Research, and Service. Measure 3- Data are from the CDC blood safety Universal Data Collection System. Measure 4 – Data provided by the Division of Human Development and Disability's Child Development Studies Team. Measure 6 - Data are from MD STARnet.			
Data Validation: Measures 1 and 5 - Data obtained from the DSHPSHWA are collected on an annual basis. A survey section is included for states to provide updated data from the previous year. Data are compared at CDC to monitor the quality of data being reported. Additionally, data from the National Center for Health Statistics are used to verify the reported number of live births reported by each EHDI program. Measure 2 - CDC verifies the data on an ongoing basis but no less than quarterly by contacting grantees at the University of Montana via phone or e-mail to confirm states where training has taken place for implementing the Living Well With a Disability Program. Measure 3 - For those grantees that participate in electronic form submission, the data are updated in real time. For all others CDC verifies the data quarterly. Measure 4 - Publications are made possible as a result of analyses of *Legacy for Children* data. Measure 6 - CDC verifies the data on an ongoing basis but no less than quarterly by contacting grantees at MD STARnet sites via phone or e-mail or phone to ensure a high level of quality among surveillance sites.			
Cross Reference: Measure 1 - HHS-5, HP-28.11, 500-1; Measure 2 - HHS-3, 6, HP-6.1-13, 500-1; Measure 3 - HHS-1, PART; Measure 4- HHS-1,7; 500-5; HP 19, 21, 25, 26, 27, PART; Measure 5- HHS-3, 6, HP-6.1-13, 500-1, PART; Measure 6 - HHS 3.5, 5, 500-1, PART			

Goal 2, Performance Measure 1:

CDC is collaborating with the Health Resources and Services Administration (HRSA) to help states implement the new Early Hearing Detection and Intervention (EHDI) program. CDC helps states establish programs to track children who screen positive for hearing loss and ensure that these children get follow-up diagnostic testing and, if needed, enter early intervention programs. At this early stage in the program, CDC targets efforts to measure the impact of the first and second phases in this process to track the number of children initially screened for hearing loss in the hospital and the number evaluated by a trained audiologist to confirm or deny screening results. Even this seemingly small step involves multiple places where children with hearing loss can be "lost to follow-up," and is essential for the achievement of targets. To help reduce the burden on states and create a central source of data, CDC, in collaboration with key partners, has designed a standardized form to gather aggregate level EHDI-related data, including "lost to follow-up." In FY 2003, CDC exceeded its target with 31 percent of newborns that screen positive for hearing loss but are lost to follow-up. This measure will be retired after data are reported for FY 2006.

Goal 2, Performance Measure 2:

CDC supports research and other programs to improve health and quality of life among people of all ages with disabilities. The primary goals of the research component are to identify risk and protective factors, develop effective prevention strategies, and assess the cost-effectiveness of health promotion interventions. One such intervention, "Living Well with a Disability," has demonstrated its ability to improve health and reduce medical costs. This intervention demonstrates the relationship between CDC-funded research and the translation of this research into public health programs. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 2, Performance Measure 3:

This measure was developed through the 2006 PART process.

CDC employs a Universal Data Collection (UDC) system to monitor blood safety through blood sample testing of individuals seen at a network of Hemophilia Treatment Centers (HTCs) across the country. Blood samples are tested for HIV, Hepatitis A, B and C and other emerging infectious agents as needed. These samples provide a national repository for the testing of emerging infectious diseases to quickly identify blood-borne infections contaminating blood products used to treat bleeding disorders and prevent transmission of infectious diseases. Given that the hemophilia population utilizes more blood products than any other group, the UDC acts as an early warning network for the identification and prevention of transmission of blood borne agents. The UDC also provides information on joint mobility and function, bleeding occurrences, treatment and vaccinations.

Goal 2, Performance Measure 4:

This measure was developed through the 2006 PART process.

Development plays a critical role in the biological and behavioral processes that impact health and well-being throughout the lifespan, but has increased importance for immediate and long-term health outcomes during infancy, early childhood, and adolescence. Healthy children are more ready to learn and are more likely to become healthy adults who will be productive members of society. Children who grow up in environments where their developmental needs are not met are at an increased risk for compromised health and safety and learning and developmental delays. In addition, it has been demonstrated that adults who were exposed to four or more adverse childhood events were at higher risk for alcoholism, drug abuse, depression, suicide attempt, smoking, poor self-rated health, multiple sexual partners, sexually transmitted disease, physical inactivity, and obesity. In response, CDC focused on developing an innovative public health intervention to promote protective factors and ameliorate risk factors impacting developmental outcomes. This intervention is currently being tested by a multi-site randomized control trial.

Goal 2, Performance Measure 5:

This measure was developed through the 2006 PART process.

CDC's activities to support early hearing detection are important for ensuring timely referral to early intervention for all infants with hearing loss. CDC supports state-based efforts to promote and ensure that all children receive a hearing screening before one month of age. This includes infants born in hospitals as well as those born in community birthing centers, homes, and other settings. There is a two year data reporting lag.

Goal 2, Performance Measure 6:

This measure was developed through the 2006 PART process.

In order to achieve this goal, CDC is engaged in the development of a population-based monitoring system designed to ascertain key health information for people with Muscular Dystrophy. This system, MD STARnet, is the only source of epidemiologic data necessary to engage in intervention research. Annual goals are set to document progress towards the health outcome. These benchmarks reflect essential steps in the public health process: public health surveillance, epidemiologic research, and intervention development and delivery.

HEALTH INFORMATION AND SERVICE

HEALTH STATISTICS

Health Statistics participated in the PART review for the 2005 cycle. This document reflects measures adopted as a result of the PART process. While they may seem redundant, there are variations in how an outcome is being measured. The PART measures are ambitious and will eventually become a permanent element of this performance plan.

Efficiency Measure	FY	Target	Result
1. Deliver timely data to the nation's health decision-makers. [E]		*a) Reduce data release time lags.*	N/A
	2006	Reduce time lags for release of core data systems by 5%; National Health Interview Survey (NHIS): Release quarterly 2007 data in 6 months from end of data collection year	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
		b) Make statistics Internet-accessible.	N/A
	2006	Make health statistics Internet-available, including the development of one new product	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
		c) Produce publications.	N/A
	2006	Produce reports and publications that document trends, issues, and problems in health.	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
2. The number of months for release of data as measured by the time from end of data collection to data release on internet. [E,O]	*2008*	**11.9**	12/2010
	2007	12.4	12/2009
	2006	12.9	12/2008
	2005	13.5	12/2007
	2004	N/A	13.8
	2003	Baseline	14.5
Data Source: Measure 1 - NHIS; Measure 2 – National Health and Nutrition Examination Survey (NHANES), National Vital Statistics System (NVSS), NHIS and the National Health Care Survey (NHCS).			
Data Validation: Measure 1 - The NHIS provides information annually on the health status of the U.S. civilian non-institutionalized population through confidential interviews conducted in households. Health Statistics has extensive quality control processes to ensure the accuracy of its data. There are many steps during the process of collecting, "cleaning up", and analyzing data that are conducted to ensure that data disseminated are of the highest quality possible. Measure 2 - Review internal information on end of data collection and release of data for NHANES, NVSS, NHIS and NHCS.			
Cross Reference: Measure 1- HHS-8, HP-1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28; Measure 2 – PART, HHS-8, HP-1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 27, 28			

Efficiency Measure 1:

a) Reduce data release time lags.

Because the National Health Interview Survey (NHIS) is conducted throughout the year, yielding a nationally representative sample each week, data can be analyzed weekly or quarterly to monitor health insurance coverage trends and other selected estimates. In FY 2006, CDC's NHIS continues to provide the most recent health insurance coverage data, as well as quarterly trend data on selected topics, such as data on usual place to go for medical care, and the prevalence of smoking for adults. Trend data for 2005 were released in June 2006. The microdata release for 2005 occurred one month earlier than last year's release. Trend data for the first half of 2006 (January to June) was released in December 2006.

CDC substituted the Early Release of Selected Estimates from the NHIS as CDC's example for this efficiency measure because it is a more accurate measure of CDC's efforts to improve timeliness, as it represents work done by CDC (rather than work done, in part, by partners outside of CDC's control).

b) Make statistics Internet accessible.

In FY 2006, CDC continues to achieve improvements in technological advances, such as the use of the Internet to make data more timely and accessible. Virtually all CDC publications are available on the Internet concurrent with their release in published form.

All CDC data are now available, from 1968 to the present, on CD-ROM. CDC also recently made its Web site accessible to visually impaired data users. Other efforts are being made to increase the accessibility and usability of the data systems and website for disabled people.

Internet-only releases, such as Health E-Stats and the Early Release of NHIS (data for the first half of 2006 were released in December 2006) help make CDC's data more accessible to the public. *Health, United States, 200*6 was released on line in November and will be mailed to data users in January.

c) Produce publications.

In FY 2006, CDC continued to lead the efforts to produce *America's Children in Brief* which was released in July 2006. *America's Children in Brief, Key National Indicators of Well-Being, 2006,* released in July 2006. This year the report is a condensed version that highlights selected indicators. The more detailed report will be published in July 2007.

Now that the data for FY 2006 have been reported, the measure is retired and will be replaced by the efficiency measure below.

Efficiency Measure 2:

Efficiency measure 2 has been developed through the PART process for the 2005 cycle and is also serving as a long-term outcome measure. Through this measure, CDC will track improvement in the timeliness of data provided to the nation's health decision makers. The measure will address Health Statistics data in the aggregate; the unit of measurement is months.

GOAL 1: MONITOR TRENDS IN THE NATION'S HEALTH THROUGH HIGH-QUALITY DATA SYSTEMS AND DELIVER TIMELY DATA TO THE NATION'S HEALTH DECISION-MAKERS.			
Measure	**FY**	**Target**	**Result**
1. Monitor the nation's health through high-quality data systems.		*a) Conduct on-going surveys*	N/A
	2006	Conduct four ongoing surveys and data systems that produce detailed trend data for monitoring health	4 (Met)
	2005	Same as above	4 (Met)
	2004	Same as above	4 (Met)
	2003	Same as above	4 (Met)
		b) Increase participant response rates	N/A

GOAL 1: MONITOR TRENDS IN THE NATION'S HEALTH THROUGH HIGH-QUALITY DATA SYSTEMS AND DELIVER TIMELY DATA TO THE NATION'S HEALTH DECISION-MAKERS.			
Measure	**FY**	**Target**	**Result**
	2006	Increase and maintain 78% participation for NHANES through improved outreach with communities, constituents, states and policy makers	78% (Met)
	2005	Same as above	78% (Met)
	2004	Same as above	75% (Unmet)
	2003	Same as above	75% (Unmet)
	2002	Baseline	78%
		c) Work with partners	N/A
	2006	Work with NAPHSIS and other partners on efforts to implement electronic death registration systems to improve the timeliness and accuracy of vital health data	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Completed work on models, standards, and specifications needed to develop re-engineered vital statistics systems (Met)
2. Percentage of key data users and policy makers, including reimbursable collaborators, that are satisfied with data quality and relevance. [O]	*2008*	**TBD**	TBD
	2007	Establish baseline upon completion of survey(s)	3/2007
3. The number of new or revised charts and tables and methodological changes in *Health, United States*, as a proxy for continuous improvement and innovation in the scope and detail of information.	*2008*	**15**	12/2008
	2007	15	12/2007
	2006	15	5 new detailed trend tables and 19 new charts (Met)
	2005	N/A	36
	2004	N/A	21
	2003	Baseline	10
4. Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data.	*2008*	**5/7.528M**	12/2008
	2007	5/7.417M	12/2007
	2006	5/6.450M	5/6.7M (Met)
	2005	N/A	5/5.608M
	2004	N/A	7/3.775M

GOAL 1: MONITOR TRENDS IN THE NATION'S HEALTH THROUGH HIGH-QUALITY DATA SYSTEMS AND DELIVER TIMELY DATA TO THE NATION'S HEALTH DECISION-MAKERS.			
Measure	**FY**	**Target**	**Result**
	2003	N/A	6/3.745M
	2002	Baseline	7/3.448M
Data Source: Measure 1 - NHANES, NHIS, National Hospital Discharge Survey (NHDS), and NVSS. Measure 2 – Health Statistics' Board of Scientific Counselors and other independent groups. Measure 3 - *Health, United States*. Measure 4 - CDC/NCHS Website.			
Data Validation: Measure 1 - NHANES: Passive quality control uses automated computer procedures for detecting data anomalies. Active quality control relies on examiner feedback to identify and evaluate problems and select remedies. NHIS: Data are reviewed and analyzed extensively to ensure their validity and reliability. NHDS: Ongoing quality control activities ensure the accuracy of the survey data. NVSS: New birth and death certificates have been designed through a collaborative effort with states, researchers, and other interested parties to enhance the accuracy of birth and death information (implemented in 2003). Measure 2 - Targets are under development. NCHS plans to implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers. Measure 3 - Improvement and innovation in *Health, United States* can be assessed through four components: a) new charts in the Chartbook; b) new trend tables; c) tables substantially revised; and d) major methodological changes. The published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation. Measure 4 – Internal checks of data.			
Cross Reference: Measure 1 - HHS-5, 500-3; Measure 2 – HHS-5, PART, 500–3; Measure 3 – HHS-5, PART, 500-3; Measure 4 – HHS-5, PART, 500-3			

Goal 1, Performance Measure 1:

a) Conduct ongoing surveys.

In FY 2006, all four targeted data systems were operating and producing detailed trend data for monitoring health. For example, one system, NHANES, identified 6,400 individuals, interviewed 5,100 and examined 5,000 individuals in 15 scientifically-selected communities across the nation to generate national estimates. The National Nursing Home Survey, a component of the National Health Care Survey conducted in 2004, surveyed long term care providers for the first time since 1999. The public-use data files were released in August 2006.

b) Increase participant response rates.

In FY 2006, NHANES achieved a 78 percent response rate through outreach with communities, constituents, states, and policy makers. CDC expects NHANES response rates will fluctuate from year to year as a result of the sample design and current conditions, and that the cumulative response rate over six years of the survey will be maintained between 77 to 78 percent.

c) Work with partners.

In FY 2006, CDC continued to work with the National Association for Public Health Statistics and Information Systems, individual states, and other agencies including the Social Security Administration to advance the re-engineering of the nation's vital statistics system. This ongoing project reached several key milestones with the development of technical specifications for electronic systems that can be followed by states and their vendors in the development of systems. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 1, Performance Measures 2 – 4:

These new measures have been developed through the PART process for the 2005 cycle and will replace the previous GPRA measure when it is retired.

Goal 1, Performance Measure 2:

This measure addresses the performance element of quality and scope. CDC will implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers (e.g., reimbursable collaborators, Assistant Secretary for Planning and Evaluation, OMB, Congressional Research Service and others) relative to data quality and scope. The Health Statistics Board of Scientific Counselors is being used to help identify the list of key data users and policy makers to be surveyed, along with those organizations that directly work with CDC through interagency agreements. Performance results will be used by CDC managers to drive program improvements.

Goal 1, Performance Measure 3:

This measure addresses the performance element of scope. *Health, United States*, the most comprehensive publication produced by CDC, draws information from each data system, as well as data from other federal partners and collaborators. Improvements in the scope and detail of *Health, United States* are a proxy for the scope of data produced and made available by CDC. Improvement and innovation in *Health, United State*s can be assessed through four components: 1) new charts in the Chartbook; 2) new trend tables; 3) tables substantially revised; and 4) major methodological changes. The published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation.

Goal 1, Performance Measure 4:

A primary objective of CDC is to maximize the use of data collected through investment of public funds. As the use of data increases, so does the return on investment. One way to increase use is to make data available in more easily accessible forms. CDC makes its data available in a variety of forms through the Internet and works to improve the speed and efficiency with which people access the data by: a) development of data input statements/programs that allow people quick access to our data files; b) development of masked variance files that allow researchers to more quickly access data; c) development of Fast Stats and Quick Stats to quickly access data files; and d) use of Beyond 20/20 software making it more likely that systems like the CDC Data Warehouse on Trends in Health and Aging, Asthma, Healthy People 2010, and *Healthy Women: State Trends in Health and Mortality,* will be found and used, thereby increasing the use of data already collected.

During 2006, the following improvements have been made on the CDC website:

- NHANES Online Tutorial provides all pertinent information researchers and policy makers need to know about analyzing current NHANES data on a web-based product. The tutorial is designed to help users navigate through the dataset and browse through different modules to gain insight into NHANES data.
- VitalStats site contains a collection of vital statistics products including pre-built tables as well as the ability for users to create tables, charts, grafts and maps based on over 100 variables. The reports allow users access to vital statistics and population data interactively.
- NCHS Survey Measures Catalog: Child and Adolescent Mental Health, provides users with an overview of the measures of child and adolescent mental health and use of mental health services in various surveys of NCHS data systems.
- The Email Subscription service provides a quick, easy way for users to request notification of changes to web pages.
- Provisional Release of NHIS is an accelerated web-based release of NHIS survey data which provides researchers and policy makers quicker access to survey data.

HEALTH MARKETING

Efficiency Measure	FY	Target	Result
1. Provide "just-in-time" scientific information and education via multiple communication channels to thousands of health professionals, thereby reducing the cost and time of distributing the latest science based information. [E]	*2008*	**5% increase from previous year in number of subscribers and participants of CDC's professional communications projects**	12/2008
	2007	5% increase from previous year in number of participants registered in distance learning activities	12/2007
	2006	5% increase from previous year in number of participants registered in distance learning activities.	99,409 (7% increase) (Exceeded)
	2005	5% increase in number of participants registered in distance learning activities.	92,790 (9% increase) (Exceeded)
	2003	Baseline	84,112 participants registered in distance learning activities
Data Source: Participant and subscriber data from the following CDC products: Morbidity and Mortality Weekly Report, Epi-X, Health Alert Network (HAN), Clinician Registry and the Public Health Training Network.			
Data Validation: Data figures are validated though the Division of Health Information Dissemination.			
Cross Reference: HHS-2, 5, HP-23			

Efficiency Measure 1:

The most important tool for frontline practitioners is current, "just-in-time" information and knowledge. Public health and healthcare information must be continuously updated, translated, and communicated to meet changing conditions and threats. Further, information must be available in the form most useful and accessible to health professionals. To meet these needs, CDC is maintaining systems for information and knowledge transfer, and ensuring that scientific and medical information is translated and communicated effectively and that the best practices of public health professionals are shared nationwide. Due to the creation of the National Center for Health Marketing in 2004, this measure has been revised to reflect that multiple communication channels are aligned beyond distance learning alone.

GOAL 1: CDC WILL MAINTAIN AND IMPROVE ITS WEBSITE AND ELECTRONIC COMMUNICATIONS TO PROVIDE SCIENCE-BASED HEALTH INFORMATION TO HEALTH CARE PROFESSIONALS, CDC PARTNERS AND THE AMERICAN PUBLIC.			
Measure	**FY**	**Target**	**Result**
1. Increase access and utilization of CDC.gov by public, partners, and other health care professionals.	*2008*	**Baseline +5%**	12/2008
	2007	Establish Baseline	12/2007
Data Source: Web usage statistics, web user performance statistics and user satisfaction statistics.			
Data Validation: Staff collect web usage statistics on an on-going basis and monitor improvements over time. User performance and user satisfaction will be measured in user testing and other user research methods (on-line surveys, interviews, etc)			
Cross Reference: HHS-8, ~~*~~-4			

Goal 1, Performance Measure 1:

CDC's web site, http://www.cdc.gov, is the primary information source for CDC's various audiences. To ensure rapid dissemination of CDC's scientific information and to ensure broad adoption and application of that scientific research into practice, CDC's scientific information must be distributed in formats (i.e., audio, video), versions (i.e., health professionals/patient) and languages used by its constituents. In addition, CDC's website must increasingly promote its content to various audiences to expedite awareness and usage of the most current scientific information available.

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.			
Measure	**FY**	**Target**	**Result**
1. Expand frontline public health practitioners' access to Internet-based, CDC-approved public health practice guidelines, scientific/disease reference images, health and medical data, and information on the effectiveness of public health interventions.	*2006*	a) Expand PHIL links to "just in time" programs by 15. b) Expand PHIL by 1,000 images over FY 2005 result	a) 65 programs (Met) b) 8,400 (Met)
	2005	a) Expand PHIL links to "just in time" programs to 50 (Baseline: 35, 05/2004) b) Expand PHIL by 3,000 images over baseline c) Design customizable functionality for the Local Health website.	a) 50 (Met) b) 7,300 images (Exceeded) c) Unmet
	2004	Expand PHIL by 3,000 images.	6,150 (Unmet)
	2003	Baseline	4,000 images
2. Increase the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools designed to provide information, educational materials, and real-time alerts as measured by the number of subscribers to Epi-X, HAN and national public health radio networks.	*2008*	**Increase by 15% above baseline**	12/2008
	2007	Increase by 5% above baseline	12/2007
	2006	Establish Baseline	3/2007
Data Source: Measure 1: Catalog of imagery on PHIL is maintained internally within the Division of Creative Services (DCS). Real time updates on numbers and downloads of imagery are captured on web interface and reported through web servers maintained by DCS personnel. Measure 2: Subscriptions to Epi-X, HAN and partner participation in the National Public Radio Network and other electronic communications systems are monitored and maintained within NCHM. Downloads and other usage information is captured to assess progress.			
Data Validation: Measure 1: PHIL staff, including team of medical illustrators, review imagery for quality before posting and review data being reported on a weekly or as needed basis. Measure 2: NCHM staff use a variety of automated and manual tracking systems to monitor usage of the various communications systems. Data are reviewed by analysts for accuracy and to determine trends in usage and gaps in services.			
Cross Reference: HHS-4, HP-23, [illegible]-5			

Goal 2, Performance Measure 1:

The Public Health Image Library (PHIL) is a unique online gallery of scientific photographs, electronic images, videos, and other digital images representing significant public health visual information. Each image includes text meta-tags describing the images that allow for searches by users who are seeking specific images for educational purposes. Clinicians, scientists, researchers, publicists, teachers, students, and the public can access PHIL and obtain images depicting everything from microorganisms to mosquitoes, rashes to risk factors. High resolution formats of the images online allow users to download and use images directly in print or electronic materials. In FY 2004, 6,150 images were digitized, referenced and archived in PHIL. The target of expanding PHIL by 3,000 images for FY 2004 was unmet. The target was not met due to an error in recording the original measure in 2004. In FY 2004, the program developed and measured a GPRA target for PHIL, estimating that the number of PHIL images would total 5,500 by the end of 2004 and 6,500 by the end of FY 2005. These measures were met and exceeded. At the end of FY 2005, the PHIL currently stands at 7,300 images. The target of designing customizable functionality for the Local Health website for FY 2005 was unmet. The PHIL has been modified to include specific audience oriented portals and interface for local public health professionals. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 2, Performance Measure 2:

Improving the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools will have immediate and lasting impact on our ability to protect citizens from natural hazards and terrorist threats. For example, CDC's Epi-X emergency alert system for public health officials nationwide could be expanded to alert other key sectors including government officials, medical officers for businesses, and health care leaders about health emergencies. CDC's online learning tools to train first responders and public health officials involved in preparing for and responding to national emergencies improves our ability to protect the U. S. This will be particularly critical in preparing for a pandemic that may isolate individuals from social gatherings, work, medical facilities, etc. CDC will establish a FY 2006 baseline by March 2007.

GOAL 3: CDC WILL MAINTAIN AND IMPROVE ITS MULTI-MEDIA BROADCAST CAPABILITIES (E.G. SATELLITE TELEVISION, WEBCASTS, PODCASTS, VIDEO) TO PROVIDE SCIENCE BASED HEALTH INFORMATION TO HEALTH CARE PROFESSIONALS, CDC PARTNERS AND THE AMERICAN PUBLIC.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of multi-media broadcast outputs to partners and health professionals.	*2008*	**Baseline +5%**	12/2008
	2007	Establish Baseline	12/2007
Data Source: The Division of Creative Services will maintain a database of multimedia broadcasts produced and delivered by the division.			
Data Validation: The Performance Management Team will review and pull reports as needed.			
Cross Reference: HHS-5, 8			

Goal 3, Performance Measure 1:

The scientific information produced by CDC is only as effective as its translation for and delivery to the many health care, partner and public audiences with which the agency interacts. Satellite distance learning broadcasts for health care professionals have been produced by CDC for many years. In addition, television can be used more broadly with broadcasts to reach the public as well as partners. With the proliferation of new technologies that allow delivery of information to very specific audiences, CDC can now access and use a broad array of multi-media channels to quickly translate science into usable information accessible in many formats (e.g., public cable television, web casts, voice pod casts, etc).

ENVIRONMENTAL HEALTH AND INJURY PREVENTION

ENVIRONMENTAL HEALTH

CDC's Environmental Health program modified some of its measures as a result of OMB feedback during the 2005 PART review process. These changes are noted in the tables and narratives below.

EFFICIENCY GOAL: PROMOTE EFFECTIVE AND EFFICIENT NCEH MANAGEMENT.			
Efficiency Measure	**FY**	**Target**	**Result**
1. By 2006, achieve a 20% cost savings and reduce the number of committee members from 28 to 16 as a result of the consolidation of the Advisory Committee to the Director, NCEH, and the Board of Scientific Counselors (BSC), ATSDR. [E]	*2006*	20%/16 members	35%/16 members (Exceeded)
	2005	10%/21 members	35%/19 members (Exceeded)
	2003	Baseline	$225,765 and 28 members
2. Number of FTE's providing program support through the Office of the Director per $1 million in total program budget. [E]	*2008*	**0.64**	10/2008
	2007	0.65	10/2007
	2006	0.66	0.55 (Exceeded)
	2005	N/A	0.67
	2003	Baseline	0.86
Data Source: Measure 1 - ATSDR's Office of Science maintains the financial records associated with the Board of Scientific Counselors (BSC) member costs. Measure 2 – NCEH/ATSDR Project Profile Database.			
Data Validation: Measure 1 - The BSC member cost report is reviewed by Committee Management and is provided to GSA annually. Measure 2 - Project Profile maps NCEH/ATSDR goals/measures and FTE's to budget.			
Cross Reference: Measure 1 - HHS-8, HP-8.12, *-1, 3; Measure 2 – HHS-8, PART			

Efficiency Measure 1:

Environmental Health's Advisory Committee merged with ATSDR's BSC in December 2004. This consolidation decreased the total number of board members and has resulted in a cost savings for FY 2005 and FY 2006. Now that the data for FY 2006 have been reported, the measure is retired and will be replaced with the new efficiency measure developed through PART listed above.

Efficiency Measure 2:

Environmental Health has taken a number of steps to become more efficient and productive, including reducing the size of the Office of the Director (OD) by decreasing the number of the office's program-support FTEs per million dollars. Further steps are being taken throughout the organization, including the following:

- CDC has achieved efficiencies in measuring environmental chemicals or their metabolites in human samples by developing new analytical biomonitoring methods and improving existing ones, making them faster, more accurate, easier to perform, and less costly.
- CDC has reduced costs and improved efficiency by making the vast majority of its materials available on the Internet. In addition to reducing printing and postal costs, electronic distribution greatly reduces the time required to deliver important information.

GOAL 1: DETERMINE HUMAN HEALTH EFFECTS ASSOCIATED WITH ENVIRONMENTAL EXPOSURES.			
Measure	**FY**	**Target**	**Result**
1. Number of environmental chemicals, including nutritional indicators, that are assessed for exposure of the U.S. population.	*2008*	**280**	12/2008
	2007	250	12/2007
	2006	180*	274 (Exceeded)
	2005	165	230 (Exceeded)
	2004	150	150 (Met)
2. Complete assessments examining the possible association between a health effect and an environmental exposure and/or hazard.	*2006*	17	30 (Exceeded)
	2005	13	21 (Exceeded)
	2004	0	3 (Exceeded)
3. Complete studies to determine the harmful health effects from environmental hazards. [1]	*2008*	**12**	12/2008
	2007	25	12/2007
	2006	25	34 (Exceeded)
	2005	6	44 (Exceeded)
	2004	2	27 (Exceeded)
4. Number of laboratory quality standards maintained in certified or participating laboratories for tests such as lipids; newborn screening; those predictive of type 1 diabetes; blood lead, cadmium, and mercury; and nutritional factors.	*2008*	**967**	12/2008
	2007	1001	12/2007
	2006	990	987 (Unmet)
	2005	982	904 (Unmet)
	2004	Baseline	866
Data Source: Environmental Health Laboratory – data systems. *Although CDC's *National Report on Human Exposure to Environmental Chemicals* is issued in odd-numbered years (from the *National Center for Health Statistics)*, the laboratory analyzes additional chemicals only in even-numbered years.			
Data Validation: Data systems at CDC's Environmental Health Laboratory monitor laboratory performance under Clinical Laboratory Improvement Amendments (CLIA). CDC also conducts quality assurance activities internally to confirm results and ensure their validity.			
Cross Reference: Measure 1 - HHS-1, 2, HP-8.24, 8.25, PART, 500-3; Measure 2 - HHS-4, 5, HP-8.28, 500-3; Measure 3 - HHS-4, HP-8.26, 500-3; Measure 4 - PART, 500-3			

[1] The target for FY 2007 was adjusted to reflect the effect of the FY 2007 Continuing Resolution for planning purposes.

Goal 1, Performance Measure 1:

Currently, CDC can measure at least 300 chemicals or their metabolites in human blood or urine. However, not all of these are yet measured in specimens obtained from participants in the National Health and Nutrition Examination Survey (NHANES). In FY 2006, the laboratory measured levels of some 274 chemicals in people who participated in NHANES and through multiple studies that the lab participates in across the nation and throughout the world. CDC will publicly release exposure data on these chemicals in July 2007 by publishing CDC's *Fourth National Report on Human Exposure to Environmental Chemicals.* Although this document is currently published every two years, the complex analyses reported in the document are conducted year-round. FY 2007 and 2008 targets have been increased in light of scientific advancements which enabled increased assessment capabilities.

Goal 1, Performance Measure 2:

The National Environmental Public Health Tracking Program funded 21 states and three local health departments (33 grants) for capacity building, and data and infrastructure enhancement activities. Of these, 12 states and one local health department (17 grants) were funded specifically to conduct data-linkage demonstration projects. In FY 2006, the program supported completion of 30 environmental public health tracking assessments examining the possible association between a health effect and an environmental exposure and/or hazard. Tracking led to 17 public health actions. For example, the Massachusetts Tracking Program found a statistically significant association between the presence of moisture problems in a school and pediatric asthma prevalence, indicating a need for public health

follow-up or intervention, and provided information for policy changes aimed at reducing mold and moisture in schools. The Tracking Program is working with school officials to identify how to remediate the moisture problems. Such efforts are helping to lay the groundwork for a National Environmental Public Health Tracking Network.

Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 1, Performance Measure 3:

Thirty-four studies were completed in FY 2006, which focused on the health effects of air pollutants such as carbon monoxide, water contaminants such as algal toxins, chemicals, and radiation. These studies focused on the health effects of air pollutants such as carbon monoxide, water contaminants such as algal toxins, chemicals, and radiation. Many of these studies were responses to specific state requests, a number of which were related to extreme weather emergencies. Targets were reduced for FY 2008 in light of proposed funding levels for all NCEH programs that contributed to this measure.

Goal 1, Performance Measure 4:

This new measure, developed though the 2005 PART process, will ensure the quality of several different tests in a large number of laboratories that participate voluntarily in these quality assurance and standardization programs. Although CDC makes every effort to encourage participation in these programs, it cannot compel laboratories to participate. The target for FY 2006 was not met because the standardization programs are entirely voluntary, and the number of labs that participate fluctuates due to multiple factors, including CDC laboratory requirements and import restrictions.

GOAL 2: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS.			
Measure	**FY**	**Target**	**Result**
1. Percentage reduction in asthma hospitalizations in states funded for partial and full implementation per 100,000 people. [O]	*2008*	**Part A Enhanced: 8% Part B: 15%**	12/2011
	2007	Part A Enhanced: 7% Part B: 14%	12/2010
	2006	Part A Enhanced: 6% Part B: 12%	12/2009
	2005	Part A Enhanced: 5% Part B: 10%	12/2008
	2002	Baseline Part A Enhanced	119
	2000	Baseline Part B	147
2. Number of children under age 6 with elevated blood lead levels. [O]	*2008*	**62,350**	6/2011
	2007	87,125	6/2010
	2006	111,900	6/2009
	2005	136,675	6/2008
	2004	N/A	240,000
	2003	Baseline	186,200
3. Prevent the spread of disease and treat malnutrition among refugees in complex humanitarian emergencies where CDC provides assistance. [O]	*2006*	90%	94% (Exceeded)
	2005	100%	100% (Met)
	2004	100%	100% (Met)
4. Percentage increase in the capacity of state health departments to anticipate and prevent the spread of illness/disease outbreaks from food– and water-borne illness.	*2008*	**90%**	12/2008
	2007	50%	12/2007
	2006	35%	90% (Exceeded)
	2005	25%	86% (Exceeded)
	2004	Baseline	16%

GOAL 2: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS.
Data Source: Measure 1 - grantee reporting; Measure 2 – NHANES; Measures 3 and 4 – Data systems are being developed.
Data Validation: Measure 1 – CDC project officers will verify that states are fulfilling the requirements of cooperative agreements through routine monitoring of the grants process. Measure 2 - Increased reporting from laboratories electronically, resulting in fewer errors introduced in data during data entry. Measures 3 and 4 – Data validation systems are being developed.
Cross Reference: Measure 1 - HHS-1, HP-24.2, PART; Measure 2 - HHS-1, HP-8.11, PART; Measure 3 - HHS-2, HP-8.29, 8.30; Measure 4 - HHS-2, HP-8.27, 8.29, PART

Goal 2, Performance Measure 1:

CDC aims to reduce hospitalizations due to asthma by helping state coalitions create and implement comprehensive asthma-control plans that include science-based interventions, partnerships, and asthma tracking systems. The asthma surveillance data is used to identify and provide interventions to people most in need, thereby preventing hospitalizations and other adverse health effects of asthma. This effort is being measured by direct target goals set by Healthy People 2010 and is driven by HHS's strategic goal to "reduce the major threats to the health and well- being of all Americans."

CDC funded 34 state/city/territory grantees in FY 2006 to develop or implement comprehensive asthma control plans. Part B grantees (Michigan, New York, Oregon, California, Illinois, and Minnesota) are funded to implement their asthma control plans fully. This measure is based on the HP 2010 goal of reducing hospitalizations for asthma (goal 24.2). Part A-enhanced (partial implementation) and B states represent 59 percent of the U.S. population.

The reporting dates for this measure have been revised to more correctly reflect the data lag. Issues regarding the quantity, quality, and non-standardized collection of asthma data in states will affect the program's ability to report on this measure. As of December 2006, CDC obtained partial data for 2003. For five of the six Part B states, the age-adjusted hospitalization rate for 2003 is 148. The baseline for Part B states is 146.95; therefore, the partial results for 2003 are not significantly different enough from the actual to make any determination about whether hospitalizations are trending up, down, or level. CDC would like to retire or modify this measure in FY 2009 and replace it with another that is more timely, measurable, and reflective of the program's focus and resources.

Goal 2, Performance Measure 2:

CDC's *Third National Report on Human Exposure to Environmental Chemicals* quantified the effectiveness of national, state and local efforts to reduce blood lead levels (BLLs) in young children (aged one to five years). The percentage of young children with elevated BLLs—10 micrograms per deciliter (µg/dl) or higher—has decreased from an estimated 4.4 percent in NHANES III (1991–1994) to 1.2 percent for 2003–2004. This decline indicates that lead exposure among young children in the general population is diminishing.

The 2004 NHANES estimates that approximately 240,000 children (1.2 percent) aged one to six years had elevated BLLs, indicating approximately a 50 percent decline in the percentage of children with elevated BLLs. This figure should be interpreted cautiously, however, because the NHANES estimates are based on small numbers of children with BLLs ≥ 10µg/dL, and there is limited experience comparing estimates intervals containing only two years of data instead of the four years preferred by CDC's National Center for Health Statistics.

Goal 2, Performance Measure 3:

The International Emergency and Refugee Health (IERH) program coordinates CDC's response to complex humanitarian emergencies, such as technical assistance to other federal agencies, the United Nations (U.N.), and organizations in areas related to the health of refugee populations. CDC provides interventions to ensure disease outbreaks are prevented from spreading among refugees and displaced persons in complex humanitarian emergencies. For example, CDC provided technical assistance and statistical support for the analysis of data from the joint nutrition and food security assessment in Darfur; conducted a nutrition and micronutrient survey and assessed U.S.-supported primary health care programs in Burmese refugee camps in Thailand; assisted UNICEF in the design and implementation of a measles immunization campaign in south Sudan, whereby an estimated 500,000 children were vaccinated; and supported U.S. government response efforts following the earthquake in Pakistan. The target for FY 2006 was decreased to 90 percent (from the FY 2005 target of 100 percent), due to limitations on staff and other resources. In some cases, providing assistance may also be against U.S. foreign policy or be otherwise inappropriate. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 2, Performance Measure 4:

This measure tracks the increased capability of states to prevent and respond to outbreaks from food, water, and air contaminants/vectors. CDC currently works with 427 state and local environmental health service (EHS) delivery programs to increase their capacity to prevent the spread of outbreaks from food- and water-borne illness. Examples include the following:

- Provided technical assistance, funds, and training to nine states in EHS-NET activities to collect, analyze, and disseminate information on the factors most likely to contribute to food- and water- borne illness and outbreaks;
- Provided technical assistance to 15 states on drinking water and recreational water supplies; and
- Funded nine state and local health departments to build or enhance environmental health services capacity built on the Ten Essential Public Health Services framework.

GOAL 3: BUILD AND ENHANCE EFFECTIVE PARTNERSHIPS TO IMPROVE ENVIRONMENTAL HEALTH CAPACITY.			
Measure	**FY**	**Target**	**Result**
1. Provide assistance to partners.	*2006*	20	20 (Met)
	2005	20	20 (Met)
	2004	20	20 (Met)
Data Source: Internal Strategic Planning Documents.			
Data Validation: Data are maintained and verified by Policy Leads in the three Environmental Health Divisions.			
Cross Reference: HHS-4, 5, HP-8.20, 8.21, 500-3			

Goal 3, Performance Measure 1:

CDC continues to develop active partnerships with a variety of partners, including state health departments, academic institutions, non-governmental organizations, and other local, state, and federal health and environmental agencies. Examples include the National Healthy Homes Training Center and Network, Eastern Kentucky University, The World Health Organization, the United Nations High Commissioner on Refugees, the World Food Program, the National Environmental Health Association, the Association of Public Health Laboratories, the Immune Deficiency Foundation, Columbia University, the University of California at Berkeley, the Mount Sinai School of Medicine, the Environmental Protection Agency, the National Aeronautics and Space Administration, the United States Geological Survey, the University of Miami, the National Institutes of Health, and the National Oceanic and Atmospheric Administration.. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

INJURY PREVENTION AND CONTROL

The National Center for Injury Prevention and Control (NCIPC) underwent the Program Rating Assessment Tool (PART) process in FY 2006 for the FY 2008 budget submission. As a result of new PART goals and measures, several of the performance budget measures have been changed or retired, and new measures have been added.

Efficiency Measure	FY	Target	Result
1. Through the implementation of web-based systems for state and territorial agencies, decrease the time between the submission of an application and the receipt of funds for injury prevention and control efforts. [E]	*2006*	Maintain FY 2005 Target	81 days average (Unmet)
	2005	5% faster	117 days average (Unmet)
	2004	Establish baseline	67 days (average)(Met)
2. Reduce the amount of time to submit funding packages for non-research funding opportunities to CDC's Procurement and Grants Office. [E]	*2008*	**14 days**	9/2008
	2007	26 days	9/2007
	2006	Establish baseline	52 days (Met)
Data Source: Measure 1 - Office of Program Management and Operations. Measure 2 - Office of Program Management and Operations.			
Data Validation: Measure 1 - Verification with CDC's NCIPC Extramural Tracking System (NEXT) data system. Measure 2 - Verification with NEXT data system.			
Cross Reference: Measure 1 - HHS-8, *-3, 4. Measure 2 - HHS-8, PART			

Efficiency Measure 1:

With an initial investment to develop the system, efficiencies are created when applications are received and processed more quickly. A web-based system also allows grantee information to be retrieved faster and more accurately than what can be collected otherwise. In addition to the time saved, this measure also improves customer service. As more applications become standardized and grantees become more familiar with their format, the grant application process will require less time and provide for more efficient means of tracking and monitoring the status of submissions. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

In FY 2005, NCIPC began the implementation process to track the new PGO baseline measures established in FY 2004. In FY 2006, the number of days decreased by 36 from FY 2005. NCIPC continues to make improvements to streamlining the process through establishing timelines and working with program personnel.

Efficiency Measure 2:

This efficiency measure will track the Injury Center's efforts to meet one of CDC's overarching Key Performance Indicators. The funding package cycle time is defined as the time from the conclusion of the review panel until the funding package is sent to CDC's Procurement and Grants Office (PGO). During this time frame, NCIPC is required to summarize the reviews (primary and secondary) of each application for a particular funding opportunity and develop a funding package document to submit to PGO. PGO's target for this time frame is seven days. In FY 2006, NCIPC took an average of 52 days to submit the funding package to PGO. NCIPC will use its NEXT system to verify its performance for this measure.

CDC's Injury Prevention program was reviewed by the Office of Management and Budget for the FY 2006 PART process. This process helped CDC redirect and refine its performance measures for injury prevention and control. Based on its PART review, CDC has revised its goals for injury prevention. CDC will track the following goals and measures (Goals 4 and 5) and will no longer report on Goals 1 through 3, after reporting for their FY 2006 targets is complete.

GOAL 1: INCREASE THE CAPACITY OF INJURY PREVENTION AND CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF INJURIES AND VIOLENCE.			
Measure	**FY**	**Target**	**Result**
1. Reduce the incidence of rape or attempted rape by increasing the number of school and college-aged people reached through educational programs.	*2006*	3% increase from previous year	12/2007
	2005	3% increase from previous year	3,195,563 (Unmet)
	2004	Establish baseline	3,328,735 (Met)
2. Among the states receiving funding from CDC, reduce deaths from residential fire. [O]	*2006*	1.27 per 100,000	2/2009
	2005	1.28 per 100,000	2/2008
	2004	1.29 per 100,000	2/2007
	2003	1.30 per 100,000	1.17 per 100,000 (Exceeded)
	2001	Baseline	1.26 per 100,000
Data Source: Measure 1 – Grantee Annual Reports; Measure 2 - National Vital Statistics System.			
Data Validation: Measure 1 – Data are checked through on-going communication with grantees and through site visits. Measure 2 – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.			
Cross Reference: Measure 1 - HHS-1, HP-15.35, 500-5; Measure 2 - HHS-1, HP-15.25, 500-5			

Goal 1, Performance Measure 1:

CDC is developing a measure to track its performance in the rape prevention and education program. A baseline of 3,328,735 school and college-aged people reached through programs supported by the Rape Prevention and Education Program has been established by collecting data from grantees through the Rape Prevention and Education Grants System. The language of this measure was modified to clarify its meaning. This measure will be retired after data have been reported for FY 2006.

The number of students reached in FY 2005 was 3,195,563; therefore, the target of a three percent increase for FY 2005 was not met. FY 2005 was the first year NCIPC implemented the process to track increases in the number of school and college-aged people through educational programs, and targets were based on best estimates of achievable results. NCIPC will continue to strive to streamline its efforts to develop strategies that are effective in educating the target population.

Goal 1, Performance Measure 2:

Residential fire deaths, among states receiving funding for residential fire prevention activities, were 1.17 per 100,000 people, which exceeds the target for FY 2003. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

GOAL 2: MONITOR AND DETECT FATAL AND NON-FATAL INJURIES.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of states receiving CDC funding to monitor, identify, and track injuries.		a) TBI Surveillance	a) TBI Surveillance
	2006	Maintain FY 2005 state funding levels	30 states funded (Met)
	2005	Maintain FY 2004 state funding levels	Met
	2004	Disseminate TBI data at state level	Met
	2003	Revise Central Nervous System (CNS) surveillance guidelines to include protocols for collecting data on mild TBI	Met
		b) NEISS All Injury Surveillance	b)NEISS All Injury Surveillance
	2006	Maintain FY 2005 activities	2005 statistics were made available to the public in September 2006

GOAL 2: MONITOR AND DETECT FATAL AND NON-FATAL INJURIES.			
Measure	**FY**	**Target**	**Result**
	2005	Provide national statistics via an Internet-based electronic reporting system made available to the public	Met
	2004	Publish national statistics on non-fatal injuries treated in emergency departments by leading causes of injury	Met
	2003	Implement an NEISS All Injury Program special study on traumatic brain injury	Met
		c) NVDRS Surveillance	c) NVDRS Surveillance
	2006	Maintain FY 2005 state funding levels to continue implementing NVDRS	17 states funded (Met)
	2005	Maintain FY 2004 state funding levels to continue implementing NVDRS	17 states funded (Met)
	2004	Maintain FY 2003 state funding levels to continue implementing NVDRS	17 states funded (Exceeded)
	2003	Increase the number of states implementing NVDRS from 6 to 8	13 states funded (Exceeded)
Data Source: a) Division of Injury and Disability, Outcomes & Programs; b) Office of Statistics and Programming; c) Division of Violence Prevention			
Data Validation: Verification with NCIPC Extramural Tracking System (NEXT) data system			
Cross Reference: HHS-5, HP-15.1, 15.10, 500-5			

Goal 2, Performance Measure 1:

a) Traumatic Brain Injury (TBI) Surveillance – CDC's Public Health Injury Surveillance and Prevention Program funds 30 state health departments to conduct injury surveillance, including reporting the number of people who die or are hospitalized with a TBI.

b) National Electronic Injury Surveillance System (NEISS) – NEISS, funded by CDC in collaboration with the U.S. Consumer Product Safety Commission (CPSC), provides injury data from inner city, urban, suburban, and rural children's hospitals. CDC uses NEISS data to generate national estimates of nonfatal injuries in the U.S. and to guide decisions and policies about injury prevention and control. National statistics on nonfatal injuries treated in emergency departments can be accessed via the internet at http://www.cdc.gov/ncipc/wisqars/default.htm, meeting the target that was established for FY 2005.

c) National Violent Death Reporting System (NVDRS) – In FY 2005, CDC funded 17 states to implement NVDRS, gathering and sharing state-level data about violent deaths. This state-based system collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. This information can be used to develop, inform, and evaluate violence prevention programs. CDC met the target established for both FY 2005 and FY 2006.

Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

GOAL 3: CONDUCT A TARGETED PROGRAM OF RESEARCH TO REDUCE INJURY-RELATED DEATH AND DISABILITY.			
Measure	**FY**	**Target**	**Result**
1. Develop new or improved approaches to prevent and control death and disability due to injuries.	*2006*	Maintain FY 2005 funding level for research agenda targeted areas; peer review 98% of research projects	Maintained funding for targeted areas, 98% of research projects peer reviewed (Met)
	2005	Maintain FY 2004 funding level for research agenda targeted areas; peer review 98% of research projects	Maintained funding for targeted areas, 98% of research projects peer reviewed (Met)
	2004	Maintain FY 2003 funding level for research agenda targeted areas; increase peer-review by 5%	Maintained funding for targeted areas, 93% of research awards peer-reviewed (Exceeded)
	2003	Fund one research project for injury research in targeted areas; increase peer-review by 5%	90% of research awards peer-reviewed (Exceeded)
	2002	Baseline	66% of research awards peer-reviewed; 134 projects funded
Data Source: Office of Extramural Research.			
Data Validation: Verification with NCIPC Extramural Tracking System (NEXT) data system.			
Cross Reference: HHS-4, HP-15, 500-3			

Goal 3, Performance Measure 1:

CDC research focuses on reducing morbidity, disability, death, and lowering costs associated with injuries. CDC's extramural research program supports the following:

- Research centers for broad-based injury control.
- Centers for youth violence prevention.
- Individual, investigator-initiated research that is targeted to specific studies.
- Grants for small business innovative research.

CDC also conducts evaluation research to ascertain the efficacy and effectiveness of interventions and other factors that put people at risk for injury. The extramural program supports a productive and relevant research portfolio and uses a peer review approach that is based on review by the Injury Research Grant Review Committee (IRGRC). IRGRC is composed of experts in injury-related scientific disciplines or current research areas that enable them to evaluate the scientific and technical merits of grant applications. CDC achieved this measure in FY 2006. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Following the 2006 PART review, Injury will continue to measure Goals 4 and 5 as reported below.

GOAL 4: ACHIEVE REDUCTIONS IN THE BURDEN OF INJURIES, DISABILITY, OR DEATH FROM INTENTIONAL INJURIES FOR PEOPLE AT ALL LIFE STAGES.			
Measure	**FY**	**Target**	**Result**
1. Reduce youth homicide rate by 0.1 per 100,000 annually. [O]	*2008*	**8.8/100,000**	2/2010
	2005	8.9/100,000	2/2007
	2004	N/A	8.9/100,000
	2003	Baseline	9.4/100,000
2. Reduce victimization of youth enrolled in grades 9-12 as measured by a reduction in the lifetime prevalence of unwanted sexual intercourse, the 12-month incidence of dating violence, and the 12-month incidence of physical fighting. [O]	*2009*	A) 6.7% B) 8.1% C) 29.3%	12/2010
	2007	A) 6.9% B) 8.4% C) 30.3%	12/2008
	2005	A) 7.2% B) 8.8% C) 31.3%	A) 7.5% B) 9.2% (Unmet) C) 35.9% (Unmet)
	2003	N/A	A) 9.0% B) 8.9% C) 33.0%
	2001	Baseline	A) 7.7% B) 9.5% C) 33.2%
Data Source: Measure 1 – National Violent Death Reporting System (NVDRS), Measure 2 - Youth Risk Behavior Survey			
Data Validation: Measure 1 – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis. Measure 2 – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.			
Cross Reference: Measure 1 - HHS-1, HP-15.32, PART. Measure 2 - HHS-1, HP-15.34, HP-15.35, HP-15.38, PART			

Goal 4, Performance Measure 1:

This measure is monitored utilizing data from persons aged 15-24 years among states participating in the National Violent Death Reporting System in 2003. This measure contributes to CDC's long term PART goal to reduce homicide rates among youth aged 15-24 by 10 percent in NVDRS states with FY 2003 baseline data.

Youth homicide is the second leading cause of death for youth ages 15-24 years in the United States. and the fourth leading cause of death for children ages 1-14 years.

Goal 4, Performance Measure 2:

This measure contributes to CDC's long-term PART goal to impact self-reported victimization of youth as measured by reductions in two of three of the following: unwanted sexual intercourse, dating violence, and physical fighting.

NCIPC funds numerous programs and activities to address the victimization of youth. This annual performance measure consists of three aspects of victimization of youth – unwanted sexual intercourse, dating violence, and physical fighting. The data source of youth victimization is CDC's Youth Risk Behavior Survey (YRBS). In the YRBS, students enrolled in grades nine to twelve are asked these questions:

- During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?
- Have you ever been physically forced to have sexual intercourse when you did not want to?
- During the past 12 months, how many times were you in a physical fight?

This measure was not met for FY 2005, the first year of implementation of a process to track trends for the measure. Targeted reductions were the result of best estimates based on trends derived from data available during the PART review. NCIPC continues to streamline efforts to achieve its targets in reducing incidences of unwanted sexual intercourse, dating violence, and physical fighting.

GOAL 5: ACHIEVE REDUCTIONS IN THE BURDEN OF INJURIES, DISABILITY OR DEATH FROM UNINTENTIONAL INJURIES FOR PEOPLE AT ALL LIFE STAGES.			
Measure	**FY**	**Target**	**Result**
1. Among the states receiving funding from CDC, reduce deaths from residential fires by 0.01 per 100,000 population. [O]	*2008*	**1.12/100,000**	10/2010
	2007	1.13/100,000	10/2009
	2003	N/A	1.17/100,000
	2002	N/A	1.15/100,000
	2001	Baseline	1.26/100,000
2. Achieve an age-adjusted fall fatality rate among persons age 65+ of no more than 69.6 per 100,000. [O]	*2008*	**47.8/100,000**	10/2010
	2007	45.6/100,000	10/2009
	2006	43.4./100,000	10/2008
	2005	41.2/100,000	10/2007
	2004	39.0/100,000	39.2/100,000 (Unmet)
	2001	Baseline	32.5/100,000
3. Decrease the estimated percent increase of age-adjusted fall fatality rates among persons age 65+ years. [O]	*2008*	**9.30% reduction**	10/2010
	2007	9.10% reduction	10/2009
	2006	8.82% reduction	10/2008
	2005	8.39% reduction	10/2007
	2004	7.67% reduction	5.52% (Unmet)
	2001	Baseline	32.5/100,000
Data Source: Measure 1 – National Vital Statistics System; Measure 2 - National Vital Statistics System; Measure 3 - National Vital Statistics System			
Data Validation: Measures 1-3 – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.			
Cross Reference: Measure 1 – HHS-1, HP-15.25, 500-5, PART; Measure 2 - HHS-1, HP-15.14, PART ; Measure 3 - HHS-1, HP-15.14, PART			

Goal 5, Performance Measure 1:

This measure contributes to CDC's long term PART goal to reduce deaths from residential fires to 1.02 per 100,000 population among the states receiving funding from CDC. This measure reflects more ambitious targets as it includes a greater number of states, compared to the existing GPRA measure which is being retired after data are reported for FY 2006.

In 2004, fire departments responded to more than 410,000 home fires in the United States which claimed the lives of an estimated 3,190 people (not including fire fighters) and injured another 14,175. Almost half of home fire deaths occurred in homes without working smoke detectors. Residential fires accounted for approximately 80 percent of all fire-related injuries and deaths in 2004. Persons at greatest risk of sustaining fire-related injuries are children ages five years and younger and adults ages 65 and older, African Americans, Native Americans, and Alaska Natives, rural dwellers, and persons living in substandard housing or older manufactured homes.

Goal 5, Performance Measure 2:

More than one third of adults ages 65 years and older fall each year. Of those who fall, 20 percent to 30 percent suffer moderate to severe injuries such as hip fractures or head traumas that reduce mobility and independence, and increase the risk of premature death. Falls result in more than 1.8 million adults 65 years and older treated in emergency departments for fall-related injuries, over 421,000 hospitalizations, and approximately 13,000 deaths

annually. Among older adults, falls are the leading cause of injury deaths. In 2000, the direct medical cost totaled $179 million dollars for fatal falls.

In FY 2004, NCIPC began the implementation process to track the new older adult falls baseline measures. The target of 39.0 per 100,000 population was based on a best estimation of an achievable result, given trends and existing prevention efforts. The actual result of 39.2 percent did come near the target of 39.0 percent or less. NCIPC continues to streamline efforts to achieve its targets through research and dissemination of effective older adult fall prevention measures.

Goal 5, Performance Measure 3:

In 2001, the age-adjusted annual fall fatality rate among persons aged 65 years and older was 32.5 per 100,000 population. Based on a review of national data since 1981, NCIPC anticipates that fall fatality rates in this population will continue to rise over the next decade due to continuing decreases in mortality from cardiovascular and other chronic diseases, as well as increases in general life expectancy. In addition, the targeted population for this measure is will increase greatly as baby boomers age and enter the age range in large numbers. CDC estimates that the percent increase of fall fatality rates for this population without CDC activity will be 73.8 per 100,000 in 2018. With CDC's activities in this area, NCIPC has targeted an incidence rate of 69.6 per 100,000 in 2018, or a 10 percent decrease in the estimated percent increase of age-adjusted fall fatality rates.

FY 2004 was the first year NCIPC implemented the process to track reductions in increases of falls among older adults. NCIPC will continue to strive to streamline its efforts to develop strategies that are effective in getting interventions into the community in order to meet future goals.

OCCUPATIONAL SAFETY AND HEALTH

Efficiency Measure	FY	Target	Result
1. Percent of grant award/funding decisions made available to applicants within nine months of application receipt or deadline date, while maintaining a credible and efficient, two-level peer review system. [E]	*2008*	**72%**	12/2008
	2007	69%	12/2007
	2006	66%	68% (Exceeded)
	2005	Baseline	60%
2. Determine future human capital resources needed to support programmatic strategic goals, focusing on workforce development/training and succession planning. [E] A) Improve CDC NIOSH's supervisor to employee ratio by a specific % over previous year results. B) Increase the number of employees with current mission-oriented Individual Development Plans (IDPs) to a specified % of the CDC NIOSH civil service population. C) Develop succession plans for percentage of key leadership positions with anticipated retirement eligible dates for specified FYs.	*2006*	A) 2.5% over FY 2005 results. B) 65% C) 100% for FY 2008 to FY 2009.	A) Ratio 1:12.1 (Exceeded) B) 83% (Exceeded) C) 100% (Met)
	2005	A) 5% over FY 2004 results. B) 60% C) 100% for FY 2007 to FY 2008.	A) Ratio 1:11.6 (Exceeded) B) 70% (Exceeded) C) 100% (Met)
	2004	Establish Baseline	A) Ratio 1:10.98 B) IDPs 18.6% C) Succession plans 0% (All Met)
Data Source: Measure 1 - IMPAC II, the NIH grant review and administration information system, and NIOSH Office of Extramural Program tracking tools. Measure 2 - a) CDC Workforce Information Zone (WIZ), Atlanta Human Resource Center (AHRC); b) Direct report from Divisions to the NIOSH Office of the Deputy Director; c) WIZ, AHRC and formal employee queries by NIOSH Office of the Deputy Director.			
Data Validation: Measure 1 - Staff members performing award notification utilize delivery and read receipt notifications. Data is reviewed three times each year by program staff, concurrent with each review council round. Measure 2 - a) WIZ is an agency-wide program used to collect and report on human resource actions processed by the AHRC. The Office of the Deputy Director reviews pertinent data in the system monthly to assess progress in improving supervisor to employee ratio; b) Quarterly, the Office of the Deputy Director requests each Division to complete a standardized spreadsheet with basic personnel information and information on active, mission-oriented IDPs; c) Annually, the Office of the Deputy Director reviews the retirement eligibility date of NIOSH employees. Employees with eligibility dates that are current, or within the next five years, and hold a key leadership position are queried as to their retirement plans. If retirement is anticipated in the next five years, the NIOSH Lead Team establishes a succession plan to support the transition and ensure stability within the Institute.			
Cross Reference: Measure 1 – HHS-8, PART; Measure 2 - HHS-8, *-1			

Efficiency Measure 1:

CDC partners with the National Institutes of Health (NIH) Center for Scientific Review to process grant applications. In keeping with the effort to coordinate resources across HHS, CDC utilizes NIH's peer review and management system and computer program (IMPAC II) for receipt and referral of grant applications. By doing so, CDC streamlines services for the extramural community, ensures uniformity of responses to applicants, and achieves cost efficiencies for the Institute. The two-pronged approach to peer review is highly praised in the scientific community and is considered the "gold standard" for quality peer review. IMPAC II is a real-time system that can be monitored at any stage of the approval process. This review system is based on an eight to nine month timeline. This measure was developed through the 2004 PART process.

Efficiency Measure 2:

Through this measure, CDC will strive to meet the human capital goals of the President's Management Agenda, which calls for a reduction in layers of government, a reduction in the number of managers in each agency, and the ability to provide employee development and succession planning to enhance the work environment and provide future leadership. Progress is already being made towards each of these goals. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

RESEARCH

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.			
Measure	**FY**	**Target**	**Result**
1. Progress in targeting new research to the areas of occupational safety and health (OSH) most relevant to future improvements in workplace protection.	*2008*	**Evaluate relevance of fourth 1/5 of CDC NIOSH program activities according to specifications below.**	12/2009
	2007	Evaluate relevance of third 1/5 of CDC NIOSH program activities according to specifications below.	12/2008
	2006	Evaluate relevance of second 1/5 of CDC NIOSH program activities according to specifications below.	12/2007
2. Increase the relevance of occupational safety and health research for future improvements in workplace protection.	*2005*	Evaluate relevance of first 1/5 of CDC NIOSH program activities with 80% rating 4 or 5 (on a scale of 1 to 5, with 5 being the highest) as judged by independent panels of external customers, stakeholders, and experts.	2/2007
	2004	Finalize arrangements with National Academies (NA) for relevance review.	Met
	2003	Conduct baseline evaluation among safety and health professionals of CDC NIOSH research relevance for practical workplace results.	Met
3. Ensure the quality of occupational safety and health research, as measured by peer review. A) Specified % of internal research programs and % of research grants and cooperative agreements result in peer-reviewed publications within one year of project completion. B) Specified % of new internal research projects and % of new research grants and cooperative agreements are reviewed by external peer-review at project inception.	*2006*	A) 90% and 100% B) 80% and 100%	A) 90% and 100% (Met) B) 98% and 100% (Exceeded and Met)
	2005	A) 80% and 90% B) 70% and 100%	A) 89% and 90% (Exceeded and Met) B) 93% and 100% (Exceeded)
	2004	A) 70% and 80% B) 60% and 90%	A) 63% and 82% (Unmet and Exceeded) B) 86% and 100% (Exceeded)
	2003	A) 60% and 70% B) 40% and 90%	A) 62% and data not available (Exceeded) B) 60% and 100% (Exceeded)
4. Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; and measure the success of implemented intervention strategies.	*2008*	**Same target as for FY 2004**	A & B: 12/2008 C: 6/2009
	2007	Same target as for FY 2004	A & B: 12/2007 C: 6/2008

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.			
Measure	**FY**	**Target**	**Result**
	2006	Same target as for FY 2004	A) 155 research and intervention projects were based on tracking information (Met); B) 15 intervention programs used tracking information to demonstrate the success of the intervention strategy (Met); C: 6/2007
	2005	Same target as for FY 2004	A) 150 research and intervention projects were based on tracking information; B) 11 intervention programs used tracking information to demonstrate the success of the intervention strategy; C) 8.0 adults per 100,000 with elevated blood lead levels (All Met)
	2004	A) Evaluate the role that tracking information had in designing research and intervention projects. B) Identify the role that follow-up tracking information can have in assessing the success of interventions. C) Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%.	A) 153 research and intervention projects were based on tracking information; B) 21 intervention programs used tracking information to demonstrate the success of the intervention strategy; C) 3% reduction in the prevalence rate of elevated blood lead levels in adults, 16 and older (9.3 adults per 100,000) (All Met)
	2003	A) Establish a baseline by identifying those research and intervention projects that were based upon tracking information. B) Identify CDC NIOSH intervention programs that have used tracking information to demonstrate success of the intervention strategy. C) Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by establishing a baseline of the number of persons per 100,000 employed with elevated blood lead levels of 25 µg/dL or greater.	A) 187 (Baseline) B) 21 (Baseline) C) 12.0 (Baseline) (All Met)

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.			
Measure	**FY**	**Target**	**Result**
5. Percentage of NIOSH programs that will have completed program-specific outcome measures and targets in conjunction with stakeholders and customers.	*2008*	**70%**	9/2008
	2007	60%	9/2007
	2006	50%	52% (Exceeded)
	2005	33%	36% (Exceeded)
Data Source: Measures 1, 2, and 5 - National Academies (NA) direct report to NIOSH. Measure 3 - NIOSHTIC II database and NIOSH Project Planning and Management (NPPM) system. Measure 4 – a and b) NPPM system; c) National prevalence derived from the state-based Adult Blood Lead Epidemiology and Surveillance (ABLES) programs.			
Data Validation: Measures 1, 2, and 5 - NIOSH has contracted with the NA to complete reviews of at least two NIOSH sector programs annually. Upon completion of the reviews, the NA submits a formal report to NIOSH, which includes a quantitative rating of the program, summary of findings, refined outcome measures and suggestions for future improvement. Measure 3 - a) Annually, the Office of the Director develops a report on the number of publications produced by select projects using the NIOSHTIC II database and NPPM system. This report is sent to the Divisions for review, to ensure the accuracy and completion of the information; b) Internal Projects – Projects competing for new NORA funds undergo a formal external peer-review process. The NPPM system is used to identify new projects and peer review is verified by the NIOSH Associate Director for Science. External Projects - All external projects are reviewed through the NIH peer review system. The date and details of the reviews are recorded and reviewed by the NIOSH Office of Extramural Programs. Measure 4 – a and b) Program analysts in each division as well as the Office of the Director review project plans in the NPPM system to assess the use of tracking information in the development and/or completion of projects; c) NIOSH statisticians check ABLES data quarterly. Annually, the data is compiled and reviewed by the data manager using MS Access for validity of dates, ages, repeated tests on the same individual, and for completeness of data on exposure sources. Independently, a NIOSH project officer uses SAS to compare annual frequency distributions with previous years' data to check for unusual patterns, potential misclassification of exposure sources, and other data problems. The data manager and project officer then reconcile any differences in their annual analyses.			
Cross Reference: Measure 1 - HHS-4, HP-20, **-5, 500-3, PART, Measure 2 - HHS-4, HP-20, **-5, 500-3, Measure 3 - HHS-4, HP-20, **-5, 500-3, Measure 4 - HHS-4, HP-20.7, **-5, 500-3, Measure 5 - HHS-4, PART			

Goal 1, Performance Measure 1:

CDC has entered into a contract with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research program portfolio. In FY 2005, the NA Framework Committee established comprehensive evaluation criteria and assembled evaluation panels for the first phase of the review – mining and hearing loss prevention. The development of quantitative evaluation criteria was an extensive process, and took longer than expected. Once completed, the NA evaluation panels employed the criteria to conduct the first phase of the review. To provide the NA panels with ample time to conduct the review, the reporting deadline was extended. NA panels have reported on the hearing loss program and will provide a final report and rating on the mining program in early 2007. The respiratory disease and agriculture programs are also currently under review.

Goal 1, Performance Measure 2:

CDC conducts research on the full scope of occupational disease and injury, from basic research on mechanisms and etiology of occupational diseases, to applied research on specific ways to prevent disease and injury in the workplace. The NA panels will provide a final report and rating on the mining program in February 2007. Once the report is received, CDC will report the data and this measure will be retired.

Goal 1, Performance Measure 3:

CDC disseminates its research findings through a variety of publications. In FY 2006, 90 percent of internal research projects and 100 percent of CDC funded research grants and cooperative agreements for occupational safety and health resulted in peer-reviewed publications, meeting the target. Peer-reviewed publications are valuable resources, especially in the dissemination of research findings to occupational safety and health professionals. Alternative publications are also used, such as CDC numbered documents and CDC Alerts, to direct research findings to a broader audience, including employees and employers. This further promotes the translation of research findings into effective prevention practices adopted in the workplace.

In FY 2006, 98 percent of new internal research projects and 100 percent of new research grants and cooperative agreements were externally peer-reviewed at project inception. All new CDC research grants and cooperative agreements are peer-reviewed through the NIH system. CDC exceeded this portion of the FY 2006 target. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 1, Performance Measure 4:

CDC supports several state-based surveillance activities and maintains national databases of occupational injuries and fatalities. Linked to this health information is the identification of exposures to hazards that can lead to illness and injury. With this information, specific research initiatives can be undertaken to understand the relationships between exposures and health outcomes. In turn, intervention strategies are developed and implemented to reduce illness and injury.

In FY 2006, 155 research and intervention projects were based on tracking information, and 15 intervention programs used tracking information to demonstrate the effectiveness of the programs' strategies. CDC continues to reach its performance target.

Although not included in the target, many CDC projects such as training initiatives and information projects are also initiated in response to surveillance information. CDC continuing education courses, CDC Alerts and Fact Sheets may be developed for occupational safety and health professionals, employers and employees to renew concern and present prevention strategies for identified workplace hazards.

To increase tracking capabilities at the state level, CDC collaborated with the Council of State and Territorial Epidemiologists (CSTE) to complete a set of occupational health indicators that are designed to provide information about a population's health status with respect to workplace factors. In 2003, the indicators were piloted by 13 states participating in the CDC's States Occupational Surveillance Consortium (SOSC). In 2005, data from the pilot study was published, providing a broad view of occupational safety and health at the state level and differences that exist among states. Currently, all states funded by CDC for occupational health surveillance track these indicators.

Goal 1, Performance Measure 5:

As part of the National Academies (NA) comprehensive review of research activities referenced in performance measure one above, all programs will develop comprehensive outcome-based measures and targets in conjunction with stakeholders and customers. In FY 2006, 52 percent of CDC's programs – mining, construction, agriculture and health care – completed outcome measures and targets. These measures and targets formed the framework for evaluation of the impact of research by NA, and will establish transparent customer-based targets across the entire portfolio.

INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Measure	**FY**	**Target**	**Result**
1. Increase the quality, relevancy, and usefulness of CDC information and recommendations to occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	*2006*	Same target as for FY 2005	12/2007
	2005	Increase the number of occupational safety and health professionals who use CDC as a source for occupational safety and health information; continue to establish baseline.	Unmet[1] Revised survey instrument
	2004	Increase the use of CDC information and recommendations by occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	79% (Met)
	2003	Establish baseline on the percentage of occupational safety and health professionals who use occupational safety and health information published within the last 12 months by CDC.	74% (Met)
2. Increase the percentage of CDC NIOSH-trained professionals who enter the field of occupational safety and health after graduation.	*2008*	**80%**	12/2008
	2007	80%	12/2007
	2006	80%	80% (Met)
	2005	75%	80%
	2004	70%	75%
	2003	Establish baseline	68% (Met)

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Measure	**FY**	**Target**	**Result**
3. Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors. [O] A) Reduction of non-fatal injuries among youth ages 15–17. B) Reduction of fatal injuries among youth 15–17. C) Reduction in the annual number of silicosis deaths among U.S. residents age 15 and older.	*2008*	**A) 15%** **B) 30%** **C) 5%**	A) 12/2008 B) 12/2008 C) 12/2008
	2007	A) 15% B) 30% C) 5%	A) 12/2007 B) 12/2007 C) 12/2007
	2006	A) 7% B) 9% C) 5%	A) 15% (Exceeded) B) 3/2007 C) 0% (Unmet)
	2005	A) 5% B) 7% C) 5%	A) 21% (Exceeded) B) 23% (Exceeded) C) 18% (Exceeded)
	2004	A) 3% B) 5% C) 5%	A) 9.6% (Exceeded); B) 35.7% (Exceeded); C) 9.0% (Exceeded)
	2003	Establish baselines	A) 5.2 (Met) B) 3.5 (Met) C) 180 (Met)
4. Increase workplace use of control and personal protective technologies in targeted sectors. [O] A) Increase the availability of CBRN-certified respirators for use during a CBRN event to a specified % of the professional firefighters. B) Increase the percentage of U.S. pavers with installed engineering controls to a specified %.	*2006*	B) 90%	B) 6/2007
	2005	A) 15% B) 80%	A) 46% (Exceeded) B) 80% (Met)
	2004	A) 10% B) 70%	A) 13% (Exceeded) B) 70% (Met)
	2003	A) 3% B) Establish baselines	A) 3% (Met) B) 60% (Met)
5. Reduce occupational illness and injury as measured by: A) Percent reductions in respirable coal dust overexposure. B) Percent reduction in fatalities and injuries in roadway construction. C) Percent of firefighters and first responders' access to chemical, biological, radiological, and nuclear respirators. [O]	*2014*	A) 50% reduction B) 40% reduction C) 75% reduction	A) 12/2014 B) 12/2014 C) 12/2014
	2003	Baseline	A) >15% B) 154% C) >7%

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Measure	**FY**	**Target**	**Result**
6. Percentage of: A) Companies employing those with NIOSH training that rank the value added to the organization as good or excellent. B) Professionals with academic or continuing education training. [O]	*2009*	A) 80% B) Increase of 15%	A) 12/2009 B) 12/2009
	2003	Baselines	A) 68% B) 1,405 full-time academic trainees; 31,508 continuing education trainees
Data Source: Measures 1 and 6 - NIOSH Customer Satisfaction Survey. Measure 2 - NIOSH Office of Extramural Programs training grantee annual progress reports, which include performance data. Measure 3 - a) National Electronic Injury Surveillance System (NEISS); b) Census of Fatal Occupational Injuries (CFOI) special research file provided to NIOSH by Bureau of Labor Statistics; c) National Occupational Respiratory Mortality System (NORMS), an interactive query system designed to generate statistics, charts, and maps relating to mortality from occupationally-related lung diseases. Measure 4 - a) NIOSH survey of professional firefighters, and the International Safety Equipment Association (ISEA); b) NIOSH and National Asphalt Pavement Association (NAPA) collaboration. Measure 5 - a) The Mine Safety and Health Administration (MSHA) and NIOSH data sets that are shared between the agencies - MSHA data is routinely collected as part of the enforcement and compliance requirements, and NIOSH data collected during field investigations, in support of current and future research experiments.; b) See Measure 3b; c) See Measure 4a.			
Data Validation: Measures 1 and 6 - The survey is conducted by the NIOSH Education and Information Division, in compliance with the standards of the Data Quality Act. Measure 2 - OEP staff review and verify data with grantees via phone or email contact, as needed. Measure 3 - a) The Consumer Product Safety Commission (CPSC) annually visits emergency departments that submit data to NEISS to assess case capture, and review records as they are submitted for completeness and internal consistency. NIOSH receives NEISS data quarterly and reviews the subset of work-related cases that CPSC provides to ensure the cases meet NIOSH definitions of work-relatedness. NIOSH reviews a sample of cases after coding by a contractor to ensure a high level of accuracy for codes that describe source of injury and event/exposure leading to injury; b) NIOSH receives the special CFOI file annually. To avoid duplication of fatalities in the counts, source documents are matched using the decedent's name and other information. To ensure an accurate count of fatal occupational injuries, the census program requires that for each case, the work relationship (that is, whether a fatality is work related) be substantiated by two or more independent source documents or a source document and a follow-up questionnaire; c) NORMS is based on public-use, multiple cause of death data files obtained annually from the National Center for Health Statistics (NCHS). NCHS performs data quality check to remove invalid codes, verify the coding of certain rare causes of death, and ensure age/cause and sex/cause compatibility. To ensure the accuracy of the NORMS results, NIOSH compares the findings to the NCHS control tables. Measure 4 - a) NIOSH conducted a telephone survey of a representative sample of professional firefighters and analyzes proprietary data provided by ISEA for each manufacture of NIOSH-approved CBRN respiratory protective devices to assess distribution in the field. NIOSH has also incorporated questions regarding CBRN SCBA availability in the Fire Fighter Fatality Investigation and Prevention Program Evaluation Fire Department Survey, administered to 3,000 fire departments throughout the country in spring 2005; b) In 1997, the partnership between NIOSH and the National Asphalt Pavement Association (NAPA) resulted in a voluntary agreement that equipment manufacturers would incorporate effective fume emission controls on all new highway class pavers. Reports for NAPA and assessments of the average service life (10 years) for highway class pavers enable NIOSH to assess the use of pavers equipped with the recommended engineering controls. Measure 5 - a) The MSHA data is collected according to the agency's standard rigorous sampling and handling protocols. The validation of NIOSH data is ensured by following the protocols developed during the generation of the research proposals. The proposals are peer-reviewed and include calibration requirements for the measurement and handling of the dust samples, as well as procedures for analyzing the results and ensuring the meaningfulness of the data points; b) See Measure 3b; c) See Measure 4b.			
Cross Reference: Measure 1 – HHS-4, *-4, 5; Measure 2 - HHS-4, *-5, PART; Measure 3 - HHS-1, HP-20.1, 20.2, 20.4, *-5; Measure 4 - HHS-1, 2 *-5, 500-3; Measure 5 - HHS-1, PART; Measure 6 - HHS-4, *-5, PART			

[1] CDC delayed the next customer survey until 2006, to better measure the impact of this and other new communication tools.

Goal 2, Performance Measure 1:

CDC engages in capacity building activities through information dissemination. Previously, CDC assessed its capacity building capabilities through information dissemination by conducting a survey questionnaire of four professional associations. In 2005, CDC and the occupational safety and health community began efforts to redesign NORA, aligning OSH research with eight industrial sectors, to improve the impact of OSH research and information. This redesign necessitated the revision of the CDC-NIOSH Customer Satisfaction survey and the establishment of a new baseline. Pending OMB approval, the revised survey will query more than 1,500 members of various trade

associations and labor unions on the use of NIOSH information services, the utility of the information provided, and OSH information needs. The findings will assist CDC in future efforts to partner and communicate with the OSH community. Due to the necessary redesign of the survey, CDC is unable to report results for FY 2005. Once OMB approval is received, CDC will immediately begin conducting the survey. The findings of this survey will be used to establish a baseline by which progress of the new sector-based approach can be tracked.

One example of a CDC communication tool that has been successfully in disseminating information to the broad OSH community is the "NIOSH eNews". This monthly electronic newsletter is designed to provide stakeholders and researchers with a timely update on what's new in worker safety and health. Currently, more than 25,000 readers subscribe to eNews, enabling them to receive each new issue automatically by e-mail. The electronic format is versatile and interactive allowing readers to access other online resources, as well as provide CDC with comments and feedback on our performance.

Goal 2, Performance Measure 2:

This measure focuses on the effectiveness of CDC training with respect to entry into the field of occupational safety and health. CDC conducts a competitive training grant program aimed at increasing the number of professionals trained to work in the occupational safety and health field. CDC supports a network of Education and Research Centers (ERCs) and Training Project Grants (TPGs) around the country. In FY 2006, 461 professionals graduated from these programs with specialized training in disciplines that include occupational medicine, occupational health nursing, industrial hygiene, occupational safety, and other closely related occupational safety and health fields of study.

CDC estimates that about half of all U.S. occupational safety and health professionals graduate from CDC-supported programs at the masters and doctoral levels. In FY 2006, CDC met its performance goal with 80 percent of the professionals graduating from CDC-funded programs pursuing careers in occupational safety and health.

Goal 2, Performance Measure 3:

CDC translates occupational safety and health surveillance and research findings into technically and economically usable solutions to control workplace hazards and reduce work-related injuries, illnesses, and fatalities.

CDC has a long history of conducting and supporting young worker safety health research and intervention activities, and working with partners to improve young worker safety and health. In 2006, CDC produced previously unavailable data to help guide prevention efforts in the agricultural sector and led a federal interagency working group on childhood agricultural injury prevention. The agriculture sector accounts for more work-related deaths of youth than any other industrial sector. CDC also provided input into the revised child labor regulations that became effective February 14, 2005. Building upon curricula and teaching tools developed by CDC-funded grants and others, CDC is developing a core occupational safety and health curriculum for young workers that engages students and teachers in the exploration of risks to youth in the workplace, their rights and relevant labor laws, common workplace hazards and controls, communication skills, and young workers' role in emergency preparedness and response. In FY 2005, CDC worked with state educational agencies to pilot test this curriculum. CDC is currently revising the curriculum based on this pilot test and will work with partners in FY 2007 to distribute this curriculum to educators. CDC will report on sub-target B of this measure in March 2007, when updated data is published by the Bureau of Labor Statistics.

CDC is also actively working to decrease the incidence of silicosis, an irreversible but preventable disease most closely associated with occupational exposure to silica. In partnership with the DOL, CDC has established and promoted recommended exposure limits for silica and implemented the Silicosis Education Campaign. These efforts provide workers and employers in a variety of industries, including construction and mining, with a guide to working safely with the potentially hazardous compound. Although the target for FY 2006 was unmet, silicosis deaths have leveled off since the baseline was developed for this measure in FY 2003. In general, silicosis develops slowly, usually appearing 10 to 30 years after exposure. Therefore fluctuations in the annual number of silicosis deaths often do not reflect improvements made over time.

Goal 2, Performance Measure 4:

CDC has issued Chemical, Biological, Radiological and Nuclear (CBRN) Air Purifying Respirators (APR) approvals and implemented standards for upgrading traditional firefighter Self Contained Breathing Apparatus (SCBA) to CBRN protection levels. In addition to developing respirator certification standards and user guidelines, CDC is committed to ensuring that CBRN-protective respirators are available to professional firefighters. Based on a CDC/NIOSH telephone survey of professional firefighters and International Safety Equipment Association data, CDC has increased availability of CBRN-approved respirators to professional firefighters to 46 percent - exceeding the FY 2005 – FY 2007 targets. This increase is due to CDC certification of additional commercial respirators, the approval of seven additional CBRN Air Purifying Respirator models and more accurate reporting. Part A of this measure will be

retired, as targets for FY 2005 – FY 2007 have been exceeded; however information on the availability of CBRN respirators will continue to be reported in Goal 2, Performance Measure 5c.

More than 350,000 U.S. workers are exposed to fumes generated during the manufacture or use of asphalt. Asphalt fumes are known to cause irritation of the eyes and mucous membranes of the respiratory tract, and research is underway to determine if the fumes are occupational carcinogens. CDC's goal is to facilitate the installation of engineering controls on virtually all U.S. highway-class pavers. This measure will be retired after data are reported for FY 2006.

Goal 2, Performance Measure 5:

For most program activities, reductions in occupational illnesses and injuries are due to multiple factors of which research is one component. However for some sectors and activities, extenuating circumstances are minimal and efforts are at a stage where future decreases in illness and injuries logically can be attributed to the success of programs without requiring the additional level of analysis. This measure targets three such high risk sectors and activities which represent impact in (a) occupational illness (due to coal dust overexposure), (b) occupational injuries (in roadway construction), and (c) preparedness (firefighter access to CBRN respirators).

Goal 2, Performance Measure 6:

The impact of training can be evaluated as a product of two metrics: the number of trained professionals in occupational safety and health positions, and the value of these trainees to their organizations. In addition, a third metric is used to judge the success of training programs based on the satisfaction of trainees. New surveys will be conducted to augment existing data on the impact of training programs. Follow-up surveys with trainees will determine their level of satisfaction with their education, and surveys of companies hiring trainees will judge the impact they are having in the workplace. In addition, efforts will continue to track the number of professionals with occupational safety and health duties that have academic or continuing education training.

GLOBAL HEALTH

GLOBAL AIDS PROGRAM

In 2005, OMB conducted a PART review of the President's Emergency Plan for AIDS Relief (known as the Emergency Plan, or PEPFAR). The Office of the Global AIDS Coordinator (OGAC), Department of State, coordinated the review, which included activities by OGAC, the CDC Global AIDS Program (CDC/GAP), HRSA, NIH, USAID, Peace Corps, and the Departments of Defense, State, Labor, and Commerce. OMB conducted separate PART reviews of the focus country programs, other bilateral programs, and Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) activities. As a result of this review, beginning in the FY 2007 budget cycle, GAP has included performance measures for focus country programs and other bilateral programs that reflect GAP's efforts for the Emergency Plan.

GAP currently has offices in 29 countries (including the 15 focus countries) as part of coordinated interagency USG teams implementing the Emergency Plan. GAP supports more than 25 additional countries through its headquarters and regional offices. GAP assists with HIV prevention, care and treatment; laboratory capacity building; surveillance, monitoring and evaluation; and public health evaluation research through partnerships with host governments, ministries of health, non-governmental organizations, international organizations, U.S.-based universities, and the private sector to help implement the Emergency Plan, including supporting the Global Fund. GAP is uniquely positioned to coordinate with CDC's other global health programs, such as global disease detection, public health training, and prevention and control of other infectious diseases such as malaria and tuberculosis, as well as with CDC's domestic HIV/AIDS prevention programs in the United States.

As a part of the comprehensive USG Global HIV/AIDS strategy, through the Office of the Global AIDS Coordinator (OGAC), GAP has worked closely with partners including USAID and other government agencies, the World Health Organization, the World Bank, and others to develop a set of common core indicators of progress. A monitoring and evaluation plan for all activities has been developed and all countries report on their core indicators of progress on an annual basis.

GOAL 1: BY 2010, WORK WITH OTHER COUNTRIES, INTERNATIONAL ORGANIZATIONS, THE U.S. DEPARTMENT OF STATE, USAID, AND OTHER PARTNERS TO ACHIEVE THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS GOAL OF REDUCING PREVALENCE AMONG 15 TO 24 YEARS OF AGE.			
Measure	**FY**	**Target**	**Result**
1. Initiate, expand, or strengthen HIV/AIDS prevention, care, treatment, and support activities globally. (Includes all GAP funding except that specifically dedicated to the PMTCT).		*Surveillance*	*Surveillance*
	2006	24 countries[1]	24 (Met)
	2005	25 countries	25 (Met)
	2004	25 countries	25 (Met)
	2003	25 countries	25 (Met)
	2002	25 countries	25 (Met)
		Voluntary counseling and testing	*Voluntary counseling and testing*
	2006	24 countries[1]	24 (Met)
	2005	25 countries	25 (Met)
	2004	25 countries	25 (Met)
	2003	25 countries	20 (Unmet)
	2002	25 countries	20 (Unmet)
		Locally appropriate technical assistance for treatment of STDs, TB, and other opportunistic infections	*Locally appropriate technical assistance for treatment of STDs, TB, and other opportunistic infections*
	2006	24 countries[1]	24 (Met)
	2005	25 countries	25 (Met)
	2004	25 countries	23 (Unmet)
	2003	25 countries	20 (Unmet)
	2002	25 countries	20 (Unmet)

GOAL 1: BY 2010, WORK WITH OTHER COUNTRIES, INTERNATIONAL ORGANIZATIONS, THE U.S. DEPARTMENT OF STATE, USAID, AND OTHER PARTNERS TO ACHIEVE THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS GOAL OF REDUCING PREVALENCE AMONG 15 TO 24 YEARS OF AGE.
Data Source: GAP Planning and Reporting System.
Data Validation: Data are provided by each country and are checked for accuracy and inconsistencies by the GAP Monitoring and Evaluation Team.
Cross Reference: 500-6

[1] This measure was calculated based on an in-country presence of GAP staff. In 2006, CDC did not have an in-country presence in Senegal , but supported Senegal with technical assistance from HQ through the USAID office in Senegal.

Goal 1, Performance Measure 1:

Surveillance: In FY 2006, CDC supported surveillance in 24 countries and four regional offices, with a particular interest in the 15 PEPFAR focus countries.

Voluntary Counseling and Testing: In FY 2006, CDC strengthened voluntary counseling and testing (C&T) programs by providing technical assistance to ensure the quality and accuracy of HIV testing, strengthening laboratory diagnostic capabilities, identifying methods to target groups at high risk, and enhancing linkages between C&T and health and social services.

Locally Appropriate Technical Assistance for Treatment of STDs, TB, and Other Opportunistic Infections: In FY 2006, CDC worked to initiate, expand or strengthen locally appropriate technical assistance for treatment of sexually transmitted infections (STIs), TB, and other AIDS-related diseases.

Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail. It will be replaced with new measures developed for PART.

PART MEASURES

In 2005, as a result of the PART review, CDC added two new goals and accompanying performance measures to reflect the coordinated activities of GAP under the Emergency Plan. These goals reflect GAP's work in the focus countries (Goal 2) and in other bilateral programs (Goal 3). As a key implementing agency of the Emergency Plan, GAP works closely with other USG agencies and departments in the 15 focus countries to develop one country plan and annual report with indicators for each focus country. The 13 other bilateral countries received more than $5 million total in U.S. Government (USG) funds in 2005 and also report on standard indicators that reflect the efforts of all USG agencies. The new performance measures draw from these indicators and provide information on the number of individuals receiving services; targets are adjusted to reflect the latest information available by the OGAC. Measures included below are reflective of CDC's mission and programmatic activities.

GOAL 2: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN 15 FOCUS COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES TO ACHIEVE THE GOALS OF TREATING 2 MILLION HIV-INFECTED PEOPLE AND CARING FOR 10 MILLION PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS BY 2008, AND PREVENTING 7 MILLION NEW HIV INFECTIONS BY 2010.			
Focus Country Performance Measures (Includes all USG activities)			
Measure	**FY**	**Target[1]**	**Result**
1. Number of people receiving HIV/AIDS treatment.	*2008*	**1,300,000**	3/2009
	2007	860,000	3/2008
	2006	665,000	822,000
	2005	470,000	401,233 (Unmet)[2]
	2004	200,000	235,000
	2003	Baseline	66,911
2. Number of individuals provided with general HIV-related palliative care/basic health care and support during the reporting period, including TB. [O]	*2008*	Under development	3/2009
	2007	3,130,341	3/2008
	2006	2,496,157	2,464,063 (Unmet)[2]
	2005	1,662,820	1,397,555 (Unmet)
	2004	Baseline	854,800

GOAL 2: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN 15 FOCUS COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES TO ACHIEVE THE GOALS OF TREATING 2 MILLION HIV-INFECTED PEOPLE AND CARING FOR 10 MILLION PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS BY 2008, AND PREVENTING 7 MILLION NEW HIV INFECTIONS BY 2010.			
Focus Country Performance Measures (Includes all USG activities)			
Measure	**FY**	**Target[1]**	**Result**
3. Number of pregnant women receiving PMTCT services, including counseling and testing during the reporting period.	*2008*	Under development	3/2009
	2007	2,916,379	3/2008
	2006	2,100,292	2,837,409 (Met)
	2005	2,372,913	1,957,932 (Unmet)
	2004	Baseline	1,271,300
4. Number of individuals who received counseling and testing during the reporting period (counseling includes the provision of test results to clients).	*2008*	Under development	3/2009
	2007	7,671,789	3/2008
	2006	5,590,762	6,426,120 (Met)
	2005	3,982,958	4,653,257 (Met)
	2004	Baseline	1,791,900
Data Source: Country Operational Plans (COPS) database			
Data Validation: All USG data are validated by the OGAC Strategic Information team following their internal procedures.			
Cross Reference: All measures – PART, 500-6			

[1]Targets are established for entire USG efforts by the Office of the Global AIDS Coordinator (OGAC). OGAC has not released target numbers for USG measures for focus countries for those marked "Under development."
[2]These targets are set by the US Office of the Global AIDS Coordinator and represent the total USG contribution to achieving this goal. As a result, CDC cannot provide an explanation for not meeting this USG-wide target.

Goal 2, Performance Measure 1:

People receiving antiretroviral therapy (ART): Baseline 2003 numbers are an aggregate of totals from different population-based studies conducted from 1998-2002 in the 14 original focus countries.

Goal 2, Performance Measure 2:

Palliative care: Palliative care comprises a broad range of services including physical, psychological, spiritual, and social support services. Please note that beginning in 2006, both target and actual number include TB (2004 and 2005 did not include TB in either target or actuals).

Goal 2, Performance Measure 3:

PMTCT services: A program level indicator that is standardized across the 15 focus countries. Expansion of PMTCT services and programs has been a priority since the beginning of the Emergency Plan's implementation.

Goal 2, Performance Measure 4:

Counseling and Testing: A program level indicator that is standardized across the 15 focus countries.

GOAL 3: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN THE OTHER BILATERAL COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES , INTERNATIONAL AND HOST COUNTRY ORGANIZATIONS TO ACHIEVE THE GOALS OF PREVENTING NEW HIV INFECTIONS, TREATING HIV-INFECTED PEOPLE, AND CARING FOR PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS.			
Other Bilateral Countries Performance Measures (Includes all USG activities)			
Measure	**FY**	**Target[1]**	**Result**
1. Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites).	*2008*	**Under development**	3/2009
	2007	Under Development	3/2008
	2006	43,859	165,100
	2005	33,958	69,766[2] (Met)
	2004	Baseline	20,774
2. Number of individuals trained to provide laboratory-related activities.	*2008*	Under development	3/2009
	2007	Under development	3/2008
	2006	1,770	6,252
	2005	1,772	1,772 (Met)
	2004	Baseline	1,488
3. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results.	*2008*	Under development	3/2009
	2007	Under Development	3/2008
	2006	633,185	3/2007
	2005	623,787	603,913[2] (Unmet)
	2004	Baseline	145,133
4. Number of individuals who received counseling and testing during the reporting period.	*2008*	Under development	3/2009
	2007	Under Development	3/2008
	2006	1,049,628	2,485,900
	2005	955,492	1,710,048 (Met)
	2004	Baseline	773,649
Data Source: GAP Planning and Reporting System and OGAC.			
Data Validation: All USG data are validated by the OGAC Strategic Information team following their internal procedures.			
Cross Reference: All measures – PART, 500-6			

[1] Targets are established for entire USG efforts by the Office of the Global AIDS Coordinator (OGAC). OGAC has not released targets numbers for USG measures for other bilateral programs in boxes marked "Under development."
[2] This data was generated before the other bilateral countries received any specific guidance on monitoring and evaluation from OGAC. Hence, indicator values for certain programmatic activities appear low or non-existent due to lack of available existing data. Indicators include data from CDC, USAID, Peace Corps, and Department of Defense (DoD) and are based on each agency's existing indicators for reporting which were mapped into PEPFAR indicators. The reported indicators are a subset of the full set of PEPFAR indicators, i.e., only those for which FY 2005 USG data is available.

Goal 3, Performance Measure 1:

People receiving antiretroviral therapy (ART): A program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in FY 2005 USG HIV/AIDS funding. The data from 2004 and 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting (Double counting may exist due to overlap between agency programs). FY 2006 data for the other bilateral countries will not be available until March 2007.

Goal 3, Performance Measure 2:

Individuals trained in lab services: A program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in USG HIV/AIDS funding in FY 2005. This activity is run by HHS/CDC and thus will be reported on by CDC only. The data from 2004 and 2005 is from CDC and was not under the guidance of PEPFAR reporting. 2006 is the first reporting cycle that PEPFAR guidance is in effect for the countries receiving $1 million or more in USG HIV/AIDS funding. FY 2006 data for the other bilateral countries will not be available until March 2007.

Goal 3, Performance Measure 3:

PMTCT: A program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in USG HIV/AIDS funding in FY 2005. Through the Emergency Plan, the USG will continue to support counseling and testing for pregnant women, emphasizing the provision of tests results. The data from 2004 and 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting (Double counting may exist due to overlap between agency programs). 2006 is the first reporting cycle that PEPFAR guidance was in effect for the countries receiving $1 million or more in USG HIV/AIDS funding. FY 2006 data for the other bilateral countries will not be available until March 2007.

Goal 3, Performance Measure 4:

Counseling and Testing: A program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in USG HIV/AIDS funding in FY 2005. The data from 2004 and 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting (Double counting may exist due to overlap between agency programs). 2006 is the first reporting cycle that PEPFAR guidance was in effect for the countries receiving $1 million or more in USG HIV/AIDS funding. FY 2006 data for the other bilateral countries will not be available until March 2007.

GLOBAL IMMUNIZATION PROGRAM

In 2005, the Global Immunization Program underwent OMB's PART review process. New performance measures were developed as a result and are included below in the tables and narrative.

Efficiency Measure	FY	Target	Result
1. The portion of the annual budget that directly supports the program purpose in the field. [E]	*2008*	**>=90%**	4/2009
	2007	>=90%	4/2008
	2006	>=90%	4/2007
	2005	>=90%	93% (Met)
	2004	Baseline	93%
Data Source: Data will be tracked and analyzed through IRIS, GMIS, UFMS, and ICE systems.			
Data Validation: The monthly budget update is reviewed for accuracy by the Division's Associate Director for Management and Operations (ADMO). The ADMO monitors appropriate use of funds by category (polio, measles, and global disease detection) and CAN numbers. The ADMO works with the Polio Eradication Branch and the Global Measles Branch to ensure that funds are completely obligated by the end of the fiscal year. The overall budget is reviewed by the Branch Chiefs, Deputy Division Director, and Division Director quarterly.			
Cross Reference: HHS-8, PART			

Efficiency Measure:

Developed through the 2005 PART process, this measure demonstrates that most of the Global Immunization Program's funding is used to support mission-critical activities directly through CDC's global partners, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Pan American Health Organization (PAHO) and the United Nations Foundation (UNF). Specifically, these funds are used to purchase measles and polio vaccine and/or to provide technical or operational support through these agencies. To continue to meet global goals, CDC needs to maintain this efficiency and support for these activities.

GOAL 4: HELP DOMESTIC AND INTERNATIONAL PARTNERS ACHIEVE WORLD HEALTH ORGANIZATION'S GOAL OF GLOBAL POLIO ERADICATION.			
Measure	**FY**	**Target**	**Result**
1. Purchase doses of oral polio vaccine for mass immunization campaigns in Asia, Africa, and Europe.	*2008*	**425 million doses**	6/2009
	2007	425 million doses	6/2008
	2006	500 million doses	6/2007
	2005	500 million doses	428 million doses (Unmet)
	2004	500 million doses	500 million doses (Met)
	2003	600 million doses	550 million doses (Unmet)
2. Number of countries in the world with endemic wild polio virus. [O]	*2008*	**0 endemic countries**	8/2009
	2007	3 endemic countries	8/2008
	2006	4 endemic countries	8/2007
	2005	5 endemic countries	4 endemic countries (Met)
	2004	N/A	6 endemic countries
	2002	Baseline	7 endemic countries
Data Source: Measure 1 - UNICEF provides the number of doses of polio purchased with CDC funding in an annual report that is part of the CDC/UNICEF cooperative agreement. Measure 2 - WHO provides the polio case data generated from reports submitted by countries.			
Data Validation: Case count and surveillance indicators provided weekly by WHO are reviewed and analyzed by the Global Immunization Division.			
Cross Reference: Measure 1 - HHS-1; Measure 2 - HHS-1, PART			

Goal 4, Performance Measure 1:

In FY 2005, CDC purchased 428 million doses of Oral Polio Vaccine (OPV). Fewer doses were purchased than targeted for FY 2005. This was primarily due to two factors:

- OPV funding in FY 2005 was reduced slightly from FY 2004 funding levels. This was a result of decreased overall funding from FY 2004 to FY 2005 and the availability of funds from other donors for OPV, allowing CDC to use some funding to fill critical operational gaps.
- The cost of OPV increased by 10 – 20 percent, from $0.10/dose in FY 2004 to $0.11/dose in FY 2005 and $0.12/dose for monovalent OPV (mOPV). mOPV was reintroduced in FY 2005 and not used in FY 2004.

Goal 4, Performance Measure 2:

Global polio incidence has declined by more than 99 percent from 1988 to 2005. The number of endemic countries has been reduced from 125 polio-endemic countries in 1988 to four countries in early 2006 (Afghanistan, India, Nigeria and Pakistan). Egypt and Niger were removed from the list of endemic countries in January 2006, although Niger continues to have limited transmission following repeated importations of wild poliovirus from Nigeria. The target for number of endemic countries has been increased to three in FY 2007 because India, Nigeria, and likely Afghanistan will not meet the goal of ending polio transmission in 2006 due to multiple program deficiencies or accessibility issues due to conflict. About 250,000 lives have been saved and four million cases of childhood paralysis have been avoided.

In 2005, the American Region of WHO completed its fourteenth year without a reported case of polio due to the wild virus. The Western Pacific Region (includes China, Vietnam, and Cambodia among its 35 countries) and the European Region (51 countries) have achieved regional eradication of polio. However, large, ongoing polio outbreaks in northern Nigeria and western Uttar Pradesh, India are likely to delay polio eradication until 2007. As long as polio transmission occurs anywhere in the world, it remains a threat to American children. CDC will continue to fight against polio by collaborating with partners to increase the number and quality of National Immunization Days and intensify implementation of the other strategies to interrupt transmission. CDC will continue to provide scientific assistance to improve tracking to certify that polio eradication has occurred.

Measure 2 is an adaptation developed as a result of the 2005 PART process and serves as both a long-term and annual measure. The ultimate objective is to eradicate polio. The previous goal tracked cases of polio, whereas the new goal tracks number of countries with endemic polio.

GOAL 5: WORK WITH GLOBAL PARTNERS TO REDUCE THE CUMULATIVE GLOBAL MEASLES-RELATED MORTALITY BY 90% COMPARED WITH 2000 ESTIMATES (BASELINE 777,000 DEATHS) AND TO MAINTAIN ELIMINATION OF ENDEMIC MEASLES TRANSMISSION IN ALL 47 COUNTRIES OF THE AMERICAS.			
Measure	**FY**	**Target**	**Result**
1. Number of global measles-related deaths. [O]	*2008*	**327,600**	12/2009
	2007	363,400	12/2008
	2006	399,200	12/2007
	2005	435,000	345,000 (Exceeded)
	2004	500,000	454,000 (Exceeded)
	2000	Baseline	777,000
2. Number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission. [O]	*2008*	**0**	7/2009
	2007	0	6/2008
	2006	0	6/2007
	2005	0	0 (Met)
	2004	0	78 (Unmet)
	2000	Baseline	1,755
Data Source: World Health Organization, Pan American Health Organization			
Data Validation: A team of WHO epidemiologists and statisticians annually review the estimates using a standardized methodology. This is supplemented with information obtained in national surveillance and program reviews as well as special studies. In addition, WHO works with partners to examine the quality and accuracy of the data.			
Cross Reference: Measure 1 - HHS-1, PART; Measure 2 - HHS-1, PART			

Goal 5, Performance Measure 1:

CDC provided scientific, technical, and programmatic support for measles outbreak investigations in Pakistan, Tanzania, Kenya, Sudan, Georgia and the Ukraine; supported reviews of immunization surveillance in the African and the Western Pacific regions and a national review in the Republic of the Maldives and the Philippines, helped conduct a review of accelerated measles control activities in the western provinces of China, and evaluated the regional surveillance system for measles, rubella and congenital rubella syndrome in the American and European regions. CDC also contributed funding and or technical assistance to measles immunization campaigns in 23 African countries and to those planned and conducted in Afghanistan, Armenia, Bangladesh, Bhutan, Fiji Indonesia, Pakistan, Yemen, and others. These efforts resulted in recommendations for improved surveillance and control activities and contributed substantially to declines in measles mortality.

Measles has been eliminated from the Western Hemisphere. Measles mortality in the African region has been reduced by 74 percent since 1999, and measles mortality worldwide has been reduced by 60 percent. The target for this goal is based on 2000 data estimating 777,000 deaths; by 2010 CDC aims to reduce the global measles-related mortality by 90 percent compared with this estimate from 2000.

The model used to generate the preceding year coverage is based on routine and campaign related performance data that is captured by a joint WHO/UNICEF reporting form. WHO & UNICEF convene a panel committee to review this data annually and come to consensus on estimates of disease burden.

Goal 5, Performance Measure 2:

This performance measure corresponds with the goal adopted by the Pan American Health Organization (PAHO). According to available surveillance information, measles transmission has been interrupted in all countries of the Western Hemisphere since November 2002. However, imported measles cases, with limited secondary spread, continue to occur in several countries, including the U.S. Deaths from measles complications in the Americas have virtually disappeared. Globally, measles caused an estimated 345,000 deaths in 2005 and was the leading cause of death among children under five years of age from a vaccine-preventable disease.

PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

LEADERSHIP AND MANAGEMENT

OFFICE OF MINORITY HEALTH

GOAL 1: PREPARE MINORITY MEDICAL, VETERINARY, PHARMACY, AND GRADUATE STUDENTS FOR CAREERS IN PUBLIC HEALTH.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of minority students participating in the Hispanic Serving Health Professions Internship and Fellowships Program, Ferguson Emerging Infectious Disease Fellowship Program, Public Health Summer Fellowship Program, Research Initiatives for Student Enhancement (RISE) and Project IMHOTEP.	*2008*	**95**	8/2008
	2007	87	8/2007
	2006	87	91(Exceeded)
	2005	95	101 (Exceeded)
	2004	92	95 (Exceeded)
	2003	65	74 (Exceeded)
Data Source: The data source is based on the number of interns and fellows who are core-funded.			
Data Validation: Data quality assurance is measured by review of quarterly and annual program progress reports.			
Cross Reference: 500-1			

Goal 1, Performance Measure 1:

CDC surpassed the FY 2006 target to enroll 87 students in four summer training programs designed to encourage minority students to pursue graduate careers in public health and to diversify the public health workforce. Demographic data are compiled for all student training programs annually. New cooperative agreements competed under Kennedy Krieger Institute/RISE, Morehouse College/IMHOTEP, program announcements yielded more students than targeted. Collaborative and coordinated efforts among funded programs enhanced student enrollment in the summer training programs by expanding and extending the categorical program areas (i.e., medical, pharmacy, veterinary) and activities to include all Historically Black Colleges and Universities (HBCUs) with health professions schools. Coordinated efforts also provided opportunities for 12 additional students, via affiliated programs, that supported this goal.

GOAL 2: SUPPORT HBCUS AND HISPANIC SERVING INSTITUTIONS.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of funding mechanisms and the number of minority-serving institutions receiving support.	*2008*	**4 cooperative agreements; 50 schools**	8/2008
	2007	4 cooperative agreements; 47 schools	8/2007
	2006	4 cooperative agreements; 47 schools	4 cooperative agreements; (Met) 48 schools (Exceeded)
	2005	5 cooperative agreements; 75 schools	4 cooperative agreements (Unmet); 76 schools (Exceeded)
	2004	4 cooperative agreements; 69 schools	4 cooperative agreements (Met); 70 schools (Exceeded)
	2003	4 cooperative agreements; 67 schools	4 cooperative agreements (Met); 70 schools (Exceeded)
Data Source: The data source is based on the number of interns and fellows who are core-funded.			
Data Validation: Data quality assurance is measured by review of quarterly and annual program progress reports.			
Cross Reference: 500-1			

Goal 2, Performance Measure 1:

The FY 2006 performance goal to award four cooperative agreements to support Historically Black Colleges and Universities (HBCUs), and Hispanic Serving Institutions was achieved. In FY 2006, a total of 48 schools were reached, exceeding the 2006 target by one school. The targeted number of institutions projected for FY 2007 and FY 2008 were decreased because the Tribal Colleges and Universities cooperative agreement, representing 33 institutions, expired at the end of FY 2005. CDC continues to strengthen its efforts to expand and diversify partnerships with academic institutions and to increase the competence and diversity of the public health workforce.

GOAL 3: FOSTER A STRONGER COLLECTIVE DEPARTMENTAL PERSPECTIVE ON AI/AN ISSUES.			
Measure	**FY**	**Target**	**Result**
1. Working in conjunction with IHS, identify and pursue areas of mutual interest and benefit.	*2006*	1 Senior Policy Workgroup meeting	Unmet
	2005	1 Senior Policy Workgroup meeting	Unmet
Data Source: Communication between CDC/IHS senior management staff and summaries of workgroup meetings; project reports from CDC-IHS IAAs, official meeting summaries, documented activities (i.e., trainings, workshops), collaborative efforts, and CDC Financial Management Office tracking of resources allocated to IHS and tribal programs.			
Data Validation: Data quality assurance is measured by review of senior staff workgroup meeting summaries, epidemiological data sources, program progress reports, and documented outcome of collaborative efforts. All data sources are reviewed by CDC Senior Tribal Liaisons and CDC senior management (OD/OSI/OMHD).			
Cross Reference: 500-1			

Goal 3, Performance Measure 1:

During 2006, it was determined that there would be no specific Senior Policy Workgroup meeting, rather CDC and IHS senior staff would collaborate on important issues on a regular basis to maximize resources and services going to AI/AN tribes. The agencies continued to have multiple teleconferences on issues such as STD/HIV, Diabetes, closing the gap on infant mortality, pandemic influenza planning, and terrorism preparedness and response. In addition, CDC initiated discussions to strengthen IHS-CDC partnerships through the development of an umbrella Interagency Agreement (IAA) with the National Center for Health Marketing and IHS. This IAA will assist multiple CDC Centers, Offices and Divisions to have one agreement that establishes consistent measures and reporting requirements while still allowing flexibility for different programs. CDC is examining the development of a new measure focusing on AI/AN activities. Therefore, the utilization and implementation of this measure will be assessed for future use, pending an FY 2006 assessment and the availability of funding. CDC is examining the development of a new measure focusing on AI/AN activities. Therefore, the utilization and implementation of this measure will be assessed for future use, pending an FY 2006 assessment and the availability of funding.

GOAL 4: SUPPORT AND STRENGTHEN CAPACITY DEVELOPMENT STRATEGIES OF EXISTING NATIONAL AND REGIONAL MINORITY ORGANIZATIONS.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of national and regional public health collaborations with public health agencies/organizations serving minority communities via the delivery of culturally-proficient and linguistically-appropriate public health services and by developing, promoting, and marketing health promotion and professional training and educational programs and materials.	*2008*	**100**	10/2008
	2007	85	10/2007
	2006	75	477 (Exceeded)
2. Identify program and organizational infrastructure needs (i.e., policy analysis, program assessment and development, and evaluation) of public health agencies/organizations serving minority communities and provide technical assistance to improve the health status and access to programs for racial and ethnic minority populations.	*2008*	**100**	10/2008
	2007	85	10/2007
	2006	75	477 (Exceeded)
Data Sources: The data sources are based on the number of collaborative efforts, documented activities (i.e., trainings, workshops, coalition building and collaboration, leadership development, services), developed and implemented products (i.e., curriculums, guidance,), and the amount of innovative capacity building assistance (i.e., management, fiscal management, programs operations) that are provided to public health agencies/organizations serving minority communities annually.			

Data Validation: Data quality assurance is measured by review of quarterly and annual program progress reports, and documented outcome of key program activities.
Cross Reference: 500-1

Goal 4, Performance Measures 1 and 2:

FY 2006 data shows that CDC has surpassed targets for both measures to support and strengthen the capacity development strategies of existing National and Regional Minority Organizations for FY 2006. All programs have histories of providing direct or indirect service to minority and high-risk populations through a community-based approach and proven delivery system channels. They support national and/or regional initiatives to develop, expand, and enhance health promotion, educational, and community-based programs targeting racial and ethnic populations. Once funding was in place, current infrastructures and national networks allowed provided grantees with multiple mechanisms to exceed the anticipated target for Measure 1. They also allowed programs to quickly identify a multitude of program and organizational infrastructure needs relevant to Measure 2.

Final results of the FY 2007 performance goal measures for the seven cooperative agreements awarded to support and strengthen existing National and Regional Minority Organizations (NMOs/RMOs) that engage in health advocacy, promotion, education and preventive health care with the intent of improving the health and well-being of racial and ethnic minority populations will be available in October 2007.

PUBLIC HEALTH WORKFORCE DEVELOPMENT

Efficiency Measure	FY	Target	Result
1. Increase the efficiency with which the OMB Clearance package for Epi-Aids is processed, resulting in reduced number of staff hours spent in preparing the package for submission. [E]	*2006*	50 hours	12/2007
	2005	50 hours	18 hours (Met)
	2004	50 hours	22 hours (Met)
	2003	Baseline	200 hours
Data Source: Program Analyst monitors completion of Epi-Aid trip reports which includes the OMB reporting form.			
Data Validation: Completion and submission of triennial report to OMB.			
Cross Reference: HHS-8, HP-23			

Efficiency Measure 1:

This measure focuses on increasing the efficiency with which the OMB Clearance package for Epi-Aids is processed. It will result in reduced number of staff hours in preparing the package for submission and tracking the results of Epi-Aids. In 2004, the number of staff hours spent on preparing the package was 22 hours, based on 15 minutes/Epi-Aid to review 90 Epi-Aid reports to ensure the OMB reporting form is included. In FY 2005, the number of staff hours spent on preparing the package was 18 hours, based on 15 minutes/Epi-Aid to review 72 Epi-Aid reports to ensure the OMB reporting form is included. The OMB Clearance package is prepared and submitted every three years; the most recent submission was December 2006. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail. The current measure is based on where the Office of Workforce and Career Development is located within the CDC budget submission. A new measure will be developed in its place.

GOAL 1: CDC WILL DEVELOP AND IMPLEMENT TRAINING TO PROVIDE FOR AN EFFECTIVE, PREPARED, AND SUSTAINABLE HEALTH WORKFORCE ABLE TO MEET EMERGING HEALTH CHALLENGES.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of local, state, and federal health professionals who participate in training in epidemiology or public health leadership management.	*2008*	**200**	12/2009
	2007	200	12/2008
	2006	200	12/2007
	2005	200	216 (Exceeded)
	2004	200	221 (Exceeded)
Data Source: Currently, data are based on the number of fellows (EIS, PHPS, PMR) that are core funded.			
Data Validation: Staff reviews and validates data through the program's personnel system.			
Cross Reference: HHS-2, 4, HP-23, 500-1			

Goal 1, Performance Measure 1:

In a response to an August 2003 report that identified gaps at the state and local levels, CDC continues to train professional staff to address these gaps and investigate health problems affecting the nation's population.

- EIS officers participate in domestic and international infectious disease investigations.
- Preventive Medicine Residency combines clinical medical skills with public health practice expertise (e.g., epidemiology, health services management, environmental health).
- Public Health Prevention Service Program focuses on public health program management and provides experience in program planning, implementation, and evaluation through specialized hands-on training and mentorship at CDC and in state and local health agencies.

The 2004 result was revised from 258 to 221 to reflect fellows that were core-funded in FY 2004. The previous result inadvertently included EIS officers funded with non-core funds (e.g., Bioterrorism, Food Safety). Additionally, the 2005 through 2008 targets have been revised to remain constant, due to the creation of the Office of Workforce and Career Development in 2004 and uncertainty about funding limiting programmatic ability to increase the number of health professionals recruited and/or trained.

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.			
Measure	**FY**	**Target**	**Result**
1. Evaluate the impact of training programs conducted by the NLTN on laboratory practices.	*2008*	**Same at FY 2006 target**	12/2008
	2007	**Same as FY 2006 target**	12/2007
	2006	90% of the public health and clinical laboratorians attending NLTN courses can correctly handle, process, or identify potential disease agents.	CDC met this target by offering the Focus on Biosecurity Practices course (Met)
	2005	Reduce rejection rates of specimens submitted to state laboratories for newborn screening as a result of training.	Results Inconclusive (Unmet)
	2004	Assess the increase in the number of laboratories that adopt specific NCCLS practices for antimicrobial susceptibility testing and reporting.	34% increase (Baseline) (Met)
Data Source: Data for the FY 2006 – FY 2008 targets are related to laboratory safety and security. The data are collected following each course, reviewed, and evaluated by a statistician.			
Data Validation: Data are reviewed by the CDC Training Advisor responsible for the course. Collective data are checked quarterly.			
Cross Reference: HHS-2, 4, 5, HP-23			

Goal 2, Performance Measure 1:

The National Laboratory Training Network (NLTN) conducted 255 training courses and trained more than 27,000 participants through cost-effective, high quality continuing education in the laboratory sciences during the FY 2006. NLTN courses are available in a variety of formats, developed based on documented training needs, and delivered in collaboration with state public health laboratories. Course topics include bioterrorism and chemical terrorism preparedness, safe packaging and shipping of diagnostic and infectious agents, biosafety and biosecurity, antimicrobial susceptibility testing, and pandemic influenza preparedness. Selected courses from the previous year are evaluated to determine outcomes of training.

The FY 2006 target related to safety and security in the laboratory were met at 90 percent. Between January and April 2006, 324 participants from 13 states attended NLTN courses in laboratory biosecurity practices, which included information on physical security access control, information security, and training/practice drills. Additionally, a comparison of pre and post test scores showed that 226 (73.6 percent) of course participants improved their knowledge of biosecurity practices. Six months following the training, 9 (2.7 percent) of participants reported writing a biosecurity plan for their laboratory for the first time. Thirty-nine (12 percent) of course participants reported implementing positive changes in their facility in at least one of the biosecurity practice areas listed above.

This training and gathering of statistical data will continue during FY 2007.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

EFFICIENCY GOAL: PROVIDE DYNAMIC SUPPORT FOR HIGH-PRIORITY STATE AND LOCAL DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS.			
Efficiency Measure	**FY**	**Target**	**Result**
1. Eliminate the hours it takes to install GARS (Grants Application and Reporting System) software on grantees machines by establishing a Web-based system. [E]	*2005*	0 hours	12/2007
	2004	GARS becomes web-based	30% implemented (Unmet)
Data Source: Data logs that track log-ins to the web-based application.			
Data Validation: Information is electronically verified prior to transmission to CDC.			
Cross Reference: HHS-8			

Efficiency Measure 1:

A non-web-based Grants Application and Reporting System (GARS) is burdensome and inefficient for states and CDC. This burden is exacerbated as states face deep budget cuts. State health departments will save 1,952 hours per year on project reporting by using a Web-based GARS (1,952 grantee hours equals an average of four system per grantee times 61 grantees times eight hours per installation). CDC will save 720 hours, for a total saving of 2,672 hours.

The FY 2007 President's Budget proposed elimination of the Preventive Health and Health Services Block Grant. Therefore, CDC implemented only thirty percent of the highest-priority components of the system by December 2005. Given the inclusion of the PHHS Block Grant in FY 2006 budget and the indication that the program will be continued through a continuing resolution for FY 2007, CDC is proceeding with development and installation of the remaining web-based modules to make GARS fully web-based. The software development is on track at 55 percent completion. A partial implementation is planned for September 2007 and full implementation is scheduled to be completed by December 2007.

BUILDINGS AND FACILITIES

In addition to PART measures established in the 2004 review of Buildings and Facilities, CDC has implemented HHS-level Federal Real Property Council (FRPC) performance metrics. CDC used the following measures and definitions detailed in the memo, HHS Real Property Asset Management Program Performance Measures (DAS/OFMP, 8 SEP 2005), to assess its FY 2008 B&F budget submission described in the attached Program Narrative, as directed in the memo, Pre-Budget Guidance for the HHS Fiscal Year 2008 Budget (DAS/OFMP, 30 MAR 2006).

- Mission Dependency – An indication of the value an asset brings to the performance of the HHS/OPDIV mission.
- Facility Utilization – A quantitative assessment of the degree to which assets are utilized by asset type, including "Utilization Status," "Utilization Rate," and "Disposition Recommendation."
- Facility Condition – A quantitative assessment of how well an asset is being maintained in accordance with a systematic Sustainment and Improvement Strategy.
- Facility Cost – An assessment of the total operating and maintenance costs at the asset level, and positive project economics such as cash-flow or life-cycle cost analysis.

FRPC Performance Metrics

Nationwide Repairs and Improvements (R&I) Program		
FRPC Measure	**Impact**	**Explanation**
Mission Dependency		
Mission Dependency	Positive	R&I funds will be used for "mission critical" and "mission dependent" facilities in accordance with CDC's Sustainment strategy. Repair funds are used to sustain buildings in an "operational status." Improvement funds are used to modify space to bring it into alignment with current codes and reduce "overutilized" space.
Facility Utilization		
Utilization Status	Positive	R&I funds will be used for "overutilized" and "utilized" facilities in accordance with CDC's sustainment strategy.
Utilization Rate	Positive	R&I funds are used to restore assets to a condition that allows their continued effective designated use, and to improve an assets functionality or efficiency, thus maintaining or improving the utilization of the asset.
Retention/Disposal	Positive	CDC intends to use R&I funds to demolish part of 45 identified underutilized, non-mission critical, underperforming assets between 2006-2010, that are not funded through major (Capital) projects, thereby improving portfolio utilization rates and reducing costs. An additional 13 assets have been identified for disposal by 2013.
Facility Condition	Positive	As shown in the Facility Condition Index table, R&I funding at these levels will support CDC's sustainment strategy to maintain portfolio CI=90 or better.
Sustainment and Improvement Strategy	Positive	CDC has a current (2006) estimated Building Maintenance Backlog Reduction (BMAR) of $61 million. At the R&I funding levels detailed in the Facility Condition Index Table, CDC will reduce BMAR by $11.3M to achieve a minimum portfolio CI=90 by FY 2013.
Facility Cost		
O&M Cost	Positive	CDC anticipates a positive but unquantified impact on O&M costs resulting from sustainment-level R&I funding. Appropriate R&I and BSS funding will ensure that plant and equipment are operated and maintained in accordance with manufacturer's warranties, and to maximize energy and operating efficiencies.
Project Economics	N/A	

Sustainment Strategy Summary: Sustainment funding includes a combination of operations funded maintenance and minor renovations, and B&F funded repair, necessary to sustain the facility in its current condition. CDC funds sustainment through the internal Business and Services Support (BSS) activity (operations) and the nationwide Repairs and Improvements (R&I) Program (B&F).

Using data from the Automated Real Property Information System data base and individual Building Condition Assessments, CDC has projected R&I and BSS funding required from FY 2008 to FY 2013 inclusive, to improve and sustain CDC's owned assets at a minimum Condition Index (CI) of 90 as required by HHS. These projections take into account assets that CDC will propose to HHS for disposal based on the FRPC Disposition Decision Tree, as well as new assets approved, funded and under design/construction through FY 2006, and proposed assets identified in the Five-Year Plan with an out-year cost estimate (i.e., B24, B107, B108, and build-out of the Ft. Collins lab shell space). CDC's sustainment strategy incorporates the following measures:

- Base funding requests on periodically updated Facility Condition Assessments for each asset to achieve and maintain a minimum CI=90;
- Prioritize sustainment funding around mission critical assets that are appropriately utilized and can be operated and maintained in a cost effective manner;
- Continue to review the owned and leased inventory to identify assets for disposition in accordance with the FRPC's Disposition Decision Analysis framework (Please note that since the late 1990's, CDC has disposed of or earmarked for disposal over 40 non-performing assets nationwide); and,
- Continue to request recapitalization funding for new construction or modernization where appropriate to replace non-performing assets as described in the 5-Year Plan in the narrative section.

PART Performance Measures

Efficiency Measure	FY	Target	Result
1. Energy and water reduction. [E]	*2008*	**Energy 20%; Water 30%**	12/2008
	2007	Energy 20%; Water 30%	12/2007
	2006	Energy 20%; Water 30%	Energy 15% reduction; (Unmet) Water +30% (Met)
	2005	Energy 20%; Water 15%	Energy 18% reduction; Water +9% (Unmet)
	2003	Baseline	Energy 8% reduction; Water 19% reduction
2. Deliver leased space below Atlanta's sub-market rate. [E]	*2008*	**10% under market**	10/2008
	2007	10% under market	10/2007
	2006	10% under market	-10% (Met)
	2005	10% under market	-10% (Met)
	2003	Baseline	5% under market
Data Source: Measure 1 - CDC-monitored utility meters at Campus or building level, and utility bills; Measure 2 - GSA Rent bills, CDC market surveys, and commercially available data sources such as Black's Guide and CoStar.			
Data Validation: Measure 1 - Meters are owned and validated by the utility, and are checked monthly; Measure 2 - Market surveys are conducted no less than monthly and verified against GSA and commercially available data that serves as "benchmark" data for private industry.			
Cross Reference: Measure 1 and 2 – PART			

Efficiency Measure 1:

In response to Executive Order #13123 identifying specific energy reduction goals and applying water management strategies, CDC has initiated monitoring and strategic planning efforts to ensure full compliance with the Executive Order and internal water management standards.

CDC has met 75 percent of its energy goal. CDC is placing considerable emphasis on energy efficient design for its new labs, and this may result in lower future consumption. However, CDC may expect somewhat higher energy usage through the end of the projected construction period [FY 2009] as some older labs remain in service combined with additional electrical usage resulting from actual construction activities. CDC is working with HHS to bring the water metric in line with Executive Order #13123.

Efficiency Measure 2:

To demonstrate the most efficient use of taxpayer dollars, this measure will monitor leased space cost with the expectation of delivering quality space below sub-market rates. CDC used its market presence and sound negotiations to achieve below market lease rates.

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.			
Measure	**FY**	**Target**	**Result**
1. Aggregate of scores for capital projects rated on scope, schedule, budget, and quality.	*2008*	**Greater than or equal to 90%**	10/2008
	2007	Greater than or equal to 90%	10/2007
	2006	Greater than or equal to 90%	=>90% (Met)
	2005	Greater than or equal to 90%	=>90% (Met)
		Roybal Campus East Campus Consolidated Lab Project, Bldg 23	**Roybal Campus** East Campus Consolidated Lab Project, Bldg 23
	2008	**Continue construction**	6/2008
	2007	Complete design, Continue construction	6/2007
	2006	Continue design, Begin construction	Met
	2005	Continue design	Met
	2004	Begin design	Met (Pending Project and Funding Authority Approval)
		Epi Tower, Bldg 24	Epi Tower, Bldg 24
	2008	**Pending**	TBD
	2007	Pending	TBD
	2006	Pending	TBD (Pending Project and Funding Authority Approval)
	2005	Begin design	Pending (Pending Project and Funding Authority Approval)
	2004	Begin design	Pending (Pending Project and Funding Authority Approval)
		HQ & Emergency Ops Center, Bldg 21	HQ & Emergency Ops Center, Bldg 21
	2005	Complete construction	Met
	2004	Begin construction	Met
	2003	Complete design	Met
		Infrastructure and security upgrades, Bldg 20	Infrastructure and security upgrades, Bldg 20
	2008	Complete Construction	6/2008
	2007	Continue construction	6/2007
	2006	Continue construction	Met
	2005	Continue construction	Met

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.			
Measure	**FY**	**Target**	**Result**
		Scientific Communications Center, Bldg 19	Scientific Communications Center, Bldg 19
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Begin construction	Met
		Emerging Infectious Disease Lab, Bldg 18	Emerging Infectious Disease Lab, Bldg 18
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Continue construction	Met
		Chamblee Campus Environmental Health Facility, Bldg 106	**Chamblee Campus** Environmental Health Facility, Bldg 106
	2007	Complete Construction	6/2007
	2006	Complete design; Continue construction	Met
	2005	Begin design, Begin construction	Met
	2004	Design target adjusted to FY 2005	Met
		Environmental Toxicology Lab, Bldg 110	Environmental Toxicology Lab, Bldg 110
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Continue construction	Met
		Cincinnati Campus Lab Consolidation – Site Acquisition	**Cincinnati Campus** Lab Consolidation – Site Acquisition [1]
	2008	Continue analyses	10/2008
	2007	Continue analyses	10/2007
	2006	Continue analyses	Met (Pending Project and Funding Authority Approval) [1]
	2005	Continue analyses	Met (Pending Project and Funding Authority Approval) [1]
	2004	Conduct analyses	Met (Pending Project and Funding Authority Approval) [1]

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.			
Measure	**FY**	**Target**	**Result**
		Ft. Collins, CO Campus	**Ft. Collins, CO Campus**
	2007	Complete construction	2/2007
	2005	Continue construction	Met
	2004	Complete design; begin construction	Met
2. Placement of NCID & NCEH laboratorians in CDC standard space (Projects occupied or underway).	*2008*	**NCID 70%; NCEH 100%**	10/2008
	2007	NCID 70%; NCEH 100%	10/2007
	2006	NCID 70%; NCEH 100%	70%, 100% (Met)
	2005	NCID 70%, NCEH 100%	70%, 100% (Met)
3. Relationship of work orders (scheduled and unscheduled maintenance).	*2008*	**Scheduled 95%; Unscheduled 5%**	10/2008
	2007	Scheduled 95%; Unscheduled 5%	10/2007
	2006	Scheduled 95%; Unscheduled 5%	95%, 5% (Met)
	2005	Scheduled 95%, Unscheduled 5%	95%, 5% (Met)
Data Source: Measure 1 - Project Management Plans and Facility Project Approval Agreements; Measure 2 - Facility Condition Index and periodic employee census counts; Measure 3 – "The Management System (TMA)" tracking reports.			
Data Validation: Measure 1 - On-site validation in daily or weekly meetings with Project Managers and Contractors verified against approved project management plans and contractual schedule of deliveries and payments; Measure 2 - Verification or personnel counts with end-users when the buildings come on line, with additional verification through bi-annual building census. Laboratory "standard" verified through periodic (3-5 year) reviews of Facility Condition Index against published CDC laboratory and construction guidelines (Biosafety in Microbiological and Biomedical Laboratories, and CDC Design and Construction Standards); Measure 3 - Tracking performed at the work order level through TMA, with monthly verification by operations & maintenance inspection personnel.			
Cross Reference: Measure 1 – PART; Measure 2 - PART; Measure 3 – PART			

[1] Project approved by the HHS Capital Investment Review Board to proceed with only analyses needed to support project. The project has not been approved for execution and funding beyond the analysis portion. CDC is continuing with the analyses as approved.

Goal 1, Performance Measure 1:

The aggregate scoring of four vital components (scope, schedule, cost and quality) of capital construction will most accurately assess successful performance and use of appropriated funds. The four combined components provide a comprehensive snapshot of capital construction. Scope, schedule, cost and quality are identified and approved consistent with the Facilities Project Approval Agreement process. The scope component will identify the predefined project needs; the schedule component will reflect the critical milestone dates; the cost component will establish the approved project budget; and the quality component will incorporate the scoring reflecting the use of appropriate building standards and codes.

Goal 1, Performance Measure 2:

The movement of CDC laboratorians into CDC standard space will facilitate CDC's ability to meet its scientific mission. CDC standard space includes standards for bio-safety, CDC design, space planning, and accreditation of laboratory animal care and HHS utilization rate policy. This metric has underlying assumptions concerning the stability of CDC's growth rates, workforce composition, laboratory standards, and applicable codes. Any significant changes in baseline assumptions would require appropriate upward/downward adjustments to target rates.

By moving select components of the National Center for Infectious Diseases (NCID) into Building 18, the Emerging Infectious Disease Laboratory, CDC met its goal of 70 percent occupancy by NCID for 2005.

This building houses the Division of Bacterial and Mycotic Diseases (DBMD), the Division of Viral and Rickettsial Diseases (DBMD), the Division of HIV/AIDS Prevention (DHAP), HIV and Retrovirology Branch, and the Division of Viral Hepatitis (DVH). Building 18 contains unique high containment laboratory space to support research on hazardous pathogens such as Ebola, Avian Flu, and SARS. The facility is also the central receiving, processing and response lab for the CDC Bioterrorism Preparedness and Response Program and Rapid Response/Advanced Technology Lab.

With the occupancy of Building 110, the Environmental Toxicology Laboratory, CDC met 100 percent of its 2005 goal to move the National Center for Environmental Health (NCEH) into CDC standard space. This facility houses the Division of Laboratory Sciences (DLS) whose employees use advanced laboratory science and innovative techniques to prevent disease from exposure to toxic chemicals in the environment; respond to terrorism and public health emergencies involving chemicals; and improve laboratory methods to diagnose and prevent disease. Scientists are working on developing a breakthrough test for botulinum and other toxins. The Radionuclide Laboratory measures select radionuclides that might result from "dirty bombs" or other releases. CDC's award-winning Newborn Screening Quality Assurance Program is the only source in the world for ensuring the accuracy of newborn screening tests responsible for identifying thousands of babies each year who are born with genetic or metabolic disorders. In addition, Building 110 serves as the home of the world reference laboratory for measuring cholesterol, triglycerides, and high and low-density lipoproteins.

Goal 1, Performance Measure 3:

This measure will track the percentage of maintenance projects that are scheduled (i.e., planned) to maintain the facilities, versus the percentage of unscheduled work orders tied to repairs of non-functioning or faulty systems. In general, all facilities are better protected through scheduled maintenance.

TERRORISM

CDC's Upgrading CDC Capacity and Biosurveillance programs underwent the OMB PART process in 2006. As a result of the PART process, CDC developed new performance measures, including long-term outcome measures, annual outcome and output measures and an efficiency measure. This document reflects the additional measures adopted as a result of the PART process.

EFFICIENCY GOAL: CREATE PROGRAM EFFICIENCIES THAT IMPROVE SERVICES AND CONSERVE RESOURCES FOR MISSION-CRITICAL ACTIVITIES.			
Efficiency Measure	**FY**	**Target**	**Result**
1. Fully automate the application, work plan and semi-annual reporting for cooperative agreement grantees to achieve greater program efficiencies. [E] (This measure will be retired and replaced by measure 2 below)	*2006*	62 grantees	62 grantees using system (Met)
	2005	62 grantees using system	61 grantees using system (Unmet)
	2003	Baseline	57 grantees using the system, with limited functionality
2. Decrease the amount of time it takes the Division of State and Local Readiness (DSLR) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by providing appropriate tools and functionality in the DSLR Management Information System (MIS).	*2008*	25 days	12/2009
	2007	28 days	12/2008
	2006	Baseline	30 day
3. Dollars saved per $1 invested in the Food and Drug Administration's (FDA) Shelf Life Extension Program (SLEP) for available projects. [E]	*2008*	**$28**	12/2008
	2007	$26	12/2007
	2006	$24	$20 (Unmet)
	2005	Baseline	$22
4. Decrease annual costs for personnel and materials development with the development and continuous improvement to the budget and performance integration information system tools. [E]	*2008*	**$0/ BPI and Health Impact system**	12/2008
	2007	$50,000/ BPI and Health Impact system	12/2007
	2006	N/A	$86,800/BPI and Health Impact system
	2005	N/A	$101,000/Budget and Performance Integration (BPI) system
	2004	Baseline	$125,000/Excel system
Data Source: Measure 1 - CDC's Coordinating Office of Terrorism Preparedness and Emergency Response has maintained a management information system on CDC's Secure Data Network (SDN) for approximately three years. This system, known as SLPP-MIS, is used to receive, process, monitor, and evaluate cooperative agreements of over $750 million per year for 62 grantees. Measure 2 – CDC's Coordinating Office of Terrorism Preparedness and Emergency Response has maintained a management information system on CDC's Secure Data Network (SDN) for approximately three years. This system, known as SLPP-MIS, is used to receive, process, monitor, and evaluate cooperative agreements of over $750 million per year for 62 grantees. Measure 3 - CDC's SNS analysis of product Life Cycle Tools. Measure 4 - COTPER has been at the forefront of development of two information technology tools for budget and performance integration. These tools are now widely used by a variety of staff for a variety of purposes, including gaining efficiencies in the consolidation of information systems, and reducing the time required to find, collate, and use data.			
Data Validation: Measure 1 - There is an internal tracking system component of SLPP-MIS called Enhanced Project Management (EPM) that is utilized by each of the CDC DSLR project officers, as well as senior staff, to track and maintain project issues, comments, progress, and provide reporting functionality on each of the 62 grantees. Measure 2 – When the technical review process begins, the date/ time will be noted in the system; Once the target date/time is reached, the system will be closed and Project Officers will not be able to conduct additional technical reviews. Measure 3 - CDC's SNS coordinates with the FDA and maintains an internal tracking system for identification of products that may be eligible for the SLEP. Measure 4 –Health Impact and IRIS B&PI are used to track annual costs for personnel and materials development.			
Cross Reference: Measure 1 - HHS-8, PART-3, 4, 500-4; Measure 2 - 500-4; Measure 3 - PART, 500-4; Measure 4 –PART, 500-4			

Efficiency Measure 1:

In 2006, all 62 newly funded grantees used the system to fully automate their applications, work plans, and semi-annual reporting for the CDC Terrorism Preparedness cooperative agreement, resulting in greater program efficiencies. The Marshall Islands territory did not submit an application and was not provided new funding. Currently, all 62 grantees are using the system for self-reporting and reports were received in May and November 2006. The benefits of the system and new supporting processes have improved timeliness of applications, ease of processing and production for review as well as elimination of paper processing. Additionally, development of the system addresses the e-government provisions of the President's Management Agenda. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail. A new efficiency measure has been developed.

Efficiency Measure 2:

CDC's DSLR is responsible for providing management oversight and technical assistance for the administration of the Public Health Emergency Preparedness Cooperative Agreement. As part of the application process, grantees have to submit detailed work plans and budgets which can total 100 pages each. CDC Project Development Officers (PDO) need to review, provide feedback, and approve applications before funds can be awarded. In addition, at the end of the extensive review process, PDOs provide recommendations for each work plan activity and line items are restricted or disallowed for the budget. The issues cited during this review need to be monitored and resolved during the year.

Historically, PDOs conducted technical reviews of the grants using paper-based approaches. This resulted in cumbersome paperwork and difficulty in tracking resolution of issues raised during the review process. To deal with these operational limitations, CDC's Management Information System (MIS) was enhanced to centralize the collection, tracking and management of review information. MIS not only maximizes efficiency of the initial application review, but helps facilitate technical assistance efforts throughout the course of the year. The automation and integration of this process will create overall efficiencies in the grants management process by decreasing the time it takes for PDOs to conduct initial reviews and by providing rapid access to information to track and manage over time.

The efficiency gained from the integration of the review section into the MIS translates into other efficiencies from the grantees' standpoint including:

- Reduces the time that it takes grantees to get feedback regarding their work plans and budgets from Project Officers. This in turn results in a faster implementation of recommended changes thereby improving the overall efficiency of their programmatic operations.

Efficiency Measure 3:

This efficiency measure was adopted during the PART process to demonstrate the program's improved efficiencies. The return on investment (ROI) is based on each $1 spent on SLEP costs (e.g., testing, shipping, re-labeling). For FY 2006, the $20 was saved for each $1 spent on SLEP costs, falling short of the goal of $24 saved. This ROI is calculated based on the total estimated replacement costs divided by the total estimated SLEP costs. For the baseline, CDC used 10 FDA SLEP projects submitted in FY 2004.

Efficiency Measure 4:

As systems continue to improve, the goal is to gradually decrease the time and material costs required by contractors while not impacting the quality and timeliness of work developed and delivered.

PREVENTION

Preparedness goal one (Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents and naturally occurring health threats) does not currently have supporting PART or GPRA performance measures.

DETECTION AND REPORTING

PREPAREDNESS GOAL 2: DECREASE THE TIME NEEDED TO CLASSIFY HEALTH EVENTS AS TERRORISM OR NATURALLY OCCURRING IN PARTNERSHIP WITH OTHER AGENCIES.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events including those suggestive of bioterrorism.	*2008*	**3,800**	12/2008
	2007	3,400	12/2007
	2006	3,200	4,220 (Exceeded)
	2005	3,000	3,300 (Exceeded)
	2004	2,100	2,812 (Exceeded)
2. Number of top 50 metropolitan areas using BioSense. [O]	*2008*	**50**	12/2008
	2007	50	12/2007
	2006	40	38 (Unmet)
	2005	Baseline	10
3. By 2010, the BioSense program will reduce the time needed from a triggering biosurveillance event (the identification of a potential disease event or public health emergency event) to initiate event-specific standard operating procedures (the initiation of a public health investigation and, if needed, subsequent public health intervention) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. [O]	Targets Under Development		
Data Source: CDC's Epi-X network tracks the number of state and local public health professional that use the system. Measure 2 - BioSense application tracks the number of members and users of the application in a database.			
Data Validation: The number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events is captured in the Epi-X application. This number is tracked through the registration process of the application. There are automated system controls in place as well as manual procedures that are frequently conducted to validate that the information being collected is accurate. Measure 2 - The number of members and users will be reviewed on a regular basis.			
Cross Reference: Measure 1 - HHS-2, 5, *-4, 500-4; Measure 2 – HHS-2, PART, 500-4; Measure 3 - HHS-2, PART, 500-4			

Goal 2, Performance Measure 1:

Epi-X, CDC's secure Web-based communications network for public health officials, links HHS and CDC with state terrorism surveillance and response programs, provides emergency alerts, and creates a forum to share important disease information nationwide. The usefulness of Epi-X has resulted in a substantial increase in the number of users well beyond the original target numbers.

In FY 2006, 4,220 health professionals used Epi–X. The FY 2006 target was exceeded by 1,020 as a result of CDC's vigorous recruitment effort.

Goal 2, Performance Measure 2:

BioSense program officials have determined that, by 2010, all levels of public health with jurisdiction over the top 50 U.S. metropolitan areas will use BioSense for biosurveillance and local health situational awareness as needed by accessing timely (<24 hours old) healthcare data from a statistically representative population. These ambitious steps require continuous program improvement, establishment of new partnerships and data sharing agreements, information technology improvements, and realization of efficiencies. They also reflect the commitment of program resources to the President's national priorities in coordination with the Office of the National Coordinator for Health Information Technology and the American Health Information Community (AHIC). The program's FY 2005 baseline and FY 2006 data for this output measure reflect its early and dramatic progress toward this goal.

BioSense acquired real-time clinical care data from over 350 healthcare sources in FY 2006. In additional to real-time sources, BioSense also receives data from 466 Department of Defense and 863 Veteran Administration healthcare facilities. In FY 2006, all data sources cover 27 BioWatch cities and 38 major metropolitan areas.

Goal 2, Performance Measure 3:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

PREPAREDNESS GOAL 3: DECREASE THE TIME NEEDED TO DETECT AND REPORT CHEMICAL, BIOLOGICAL, RADIOLOGICAL AGENTS IN TISSUE, FOOD, OR ENVIRONMENTAL SAMPLES THAT CAUSE THREATS TO THE PUBLIC'S HEALTH.			
Measure	**FY**	**Target**	**Result**
1. 100% of states have level three chemical lab capacity, and have agreements with and access to (specimens arriving within 8 hours) a level-one chemical lab equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins.1	*2008*	**100%**	12/2008
	2007	100%	12/2007
	2006	100%	100% (Met)
	2005	25%	50% (Exceeded)
2. Maintain at 150 the number of toxic substances likely to be used in chemical terrorism that can be rapidly measured in blood and urine.	*2008*	**150 substances**	12/2008
	2007	150 substances	12/2007
	2006	150 substances	150 (Met)
	2005	150 substances	150 (Met)
	2004	150 substances	150 (Met)
3. Percentage of Laboratory Response Network (LRN) labs that pass proficiency testing for Category A and B threat agents.	*2008*	**100%**	12/2008
	2007	100%	12/2007
	2006	80%	83% (Exceeded)
	2005	75%	87% (Exceeded)
4. Number of Laboratory Response Network member laboratories able to use the current Laboratory Information Management System for electronic data exchange.	*2008*	**30**	12/2008
	2007	15	12/2007
	2006	Baseline	5
5. By 2010, the Laboratory Response Network Results Messenger will reduce the time needed from a triggering biosurveillance event (i.e., transmission of data regarding the identification of any Category A or B agent) to initiate event-specific standard operating procedures (e.g., aggregation of data at a national level) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. [O]	Targets Under Development		
6. By 2010, CDC's laboratory system will decrease the time from receipt of tissue, food and environmental samples to confirm and report chemical, biological and radiological agents to stakeholders. [O]	Targets Under Development		
Data Source: Measures 1, 2, 3 **-** The Laboratory Response Network (LRN) delivers accurate and timely identification of agents causing public health treats, including both naturally occurring disease and organisms that could be used in a biologic terrorism attack. Measure 4 - In addition to specimen and results data, the Health Level 7 (HL7) message utilized for messaging LRN data to the CDC carries information regarding the specific data source. This information will allow us to differentiate between LRN Results Messenger and a local LIMS data. Further development is underway to allow easy reporting on various types of messages from the different sources, allowing us to quickly discern the number of messages related to various programs.			
Data Validation: Measures 1,2,3 - The data collection and validation activities across the LRN significantly enhances the capacity of laboratories to rapidly detect and identify agents likely to be used in a terrorist attack and provide timely information to health professionals. Measure 4 - Messages sent to the CDC from external sources must pass through the data broker before being parsed and sent to specific programs within the CDC. The Data and Message Brokering (DMB) team will perform edits to ensure that the message is formatted properly and that we have a Collaboration Protocol Agreement (CPA) with the originating entity. The DMB team will also perform some basic edits to ensure that the message contains all required fields and will also perform validation on the vocabulary included in the message to ensure that message utilizes standard vocabulary sets (LOINC, SNOMED, etc.). In addition, we will utilize PHINMS reporting to monitor activity, such as the volume of messages received over a predefined period, from the various partners. Additional validation includes periodic review by BPRP and NCPHI resources to ensure data quality and completeness. And finally, data that is shared with other programs such as BioSense and Biological Warning and Incident Characterization (BWIC) will undergo additional validation specific to that system.			

Cross Reference: Measures 1,3,4, 5, 6 - HHS-2, PART, 500-4; Measure 2 - HHS-2, 500-4

[1]Please note that the nomenclature has changed for chemical laboratories: level-three labs are now referred to as level-one labs and level-one labs are referred to as level-three labs.

Goal 3, Performance Measure 1:

Level-three laboratories, also called sentinel laboratories, rule out the presence of agents and refer samples to reference labs through the use of specified protocols. As a public health preparedness standard, each state should have the capacity to conduct, rule-out and transfer activities. CDC is training all 62 level-three public health chemical laboratories (i.e., chemical terrorism coordinators in these laboratories) in the proper collection and shipment of human samples following a chemical terrorism event. This training also includes four items: an overview of chemical agents; CDC's responsibilities in responding to chemical terrorism events; a discussion of federal regulations on diagnostic packaging procedures and evidentiary-control measures; and hands-on exercises involving the packaging and shipping of human samples. These public health chemical laboratories will then train internal partners (e.g., hospital laboratories, HAZMAT, doctors, office laboratories) in the proper collection and shipment of human samples after a chemical-terrorism event.

In FY 2006, significant progress was made on this measure as 100 percent of states have level-three lab capacity. Fifty percent of the states are within an eight hour driving distance to a level-one chemical laboratory due to CDC's efforts in increasing the number of level-one laboratories from five to ten in FY 2005.

CDC has discouraged the development of Memorandums of Understanding (MOUs) between states for specimen analysis, resulting in a small number of existing agreements. Developing MOUs between states may not be the most efficient use of time. At any given time, a level-one laboratory may be overwhelmed with specimens from their own population or those from another state, necessitating transfer of collected specimens to another level-one laboratory. Using this rationale, a given state would have to develop at least multiple MOUs (one with each level-one laboratory) to ensure their specimens would be analyzed by each facility. Using the Emergency Management Assistance Compact (EMAC) may be a better vehicle for level-three laboratories to make sure that specimens from their population are analyzed at a level-one laboratory.

Goal 3, Performance Measure 2:

The Rapid Toxic Screen (RTS) is a series of tests to identify various chemical agents in human blood or urine. In a chemical terrorism event, RTS will help determine what chemical agents were used, who has been exposed, and to what extent. In FY 2006, CDC maintained its capacity to analyze 150 toxic substances in the event of a chemical terrorism incident or other chemical emergency. Maintenance includes ensuring proper operation of analytic instrumentation, running particle samples during proficiency testing challenges and response exercises, and providing for a stockpile of supplies and analytic materials that would allow up to 5,000 samples to be analyzed in the case of a chemical event. CDC also is identifying back-up instrumentation that could be used if our primary response instruments are "down" during an event, and is ensuring that staff is cross-trained allowing for back-up analysts if a primary analyst is unavailable during an incident.

Goal 3, Performance Measure 3:

This measure determines the readiness posture of the Laboratory Response Network (LRN) for rapid detection of biological threat agents. Since laboratories infrequently encounter biological threat agents, the proficiency testing (PT) program provides familiarity in working with these agents, performing LRN assays using agent-specific testing algorithms, and using available electronic resources to report test results.

The PT program has been in place since the LRN was founded in FY 1999. At its onset, very few LRN member laboratories were able to rapidly and accurately identify biological threat agents and other agents of public health importance. Due to testing challenges and the need for increased training, the FY 2003 baseline passing rate was approximately 75 percent. By the end of FY 2005, the passing rate rose to 83 percent and at the close of FY 2006 the passing rate increased yet again to 87 percent.

A target of 90 percent for FY 2007 and FY 2008 is recommended, an ambitious, realistic, and achievable target. There are several reasons why a 100 percent passing rate is not feasible, including: the priority threat list evolves and thus tests for new agents are introduced to LRN laboratories; and new technologies and equipment become available that require additional training and experience to master new skills. Additionally, the LRN program office at CDC is working to increase the complexity of the PT program to include multiple agents in a single challenge, testing in various non-clinical samples (e.g., food, water, and environmental samples), and requirements to complete a full testing algorithm rather than solely focusing on rapid tests. The combination of new tests, new technologies, and the

increasing complexity of the PT program suggests a 100 percent passing rate is unachievable. However, laboratories that fail a proficiency test are required to go through remediation steps that may include consultation, successful completion of a follow-up proficiency test, and/or hands-on training.

Goal 3, Performance Measure 4:

The Laboratory Information Management System (LIMS) Integration Team is dedicated to producing tools to help laboratories enable standard electronic exchange of LRN data using their own laboratory information management systems (LIMS). Achieving the long-term objective for the LRN Results Messenger reflects the need to develop, maintain, and expand information technology solutions for rapid exchange of laboratory results to continuously reduce the amount of time required for critical results to be identified and reported. This requires continuous program improvement, establishment of new partnerships and data sharing agreements, information technology improvements, and realization of efficiencies. Currently, the best marker for network laboratories to indicate their readiness to improve timely reporting for action is their ability to utilize their current LIMS for electronic data exchange to 136 (the current number of member laboratories).

Goal 3, Performance Measure 5:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

Goal 3, Performance Measure 6:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to identify events of national public health importance and indirectly will decrease the time needed to communicate with the public about important health issues, initiate investigations, and to identify and provide countermeasures.

PREPAREDNESS GOAL 4: IMPROVE THE TIMELINESS AND ACCURACY OF COMMUNICATIONS REGARDING THREATS TO THE PUBLIC'S HEALTH.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of states and major metropolitan areas with access to Epi-X.	*2008*	**250**	12/2008
	2007	225	12/2007
	2006	150	154 (Exceeded)
	2005	125	137 (Exceeded)
	2004	100	100 (Met)
2. 100% of LRN labs will report routine public health testing results through standards-based electronic disease surveillance systems and have protocols for immediate reporting by telephone for Category A agents (bacillus anthracis, yersina pestis, francisella tularensis, clostridium botulinum toxin and variola major) for which they conduct testing. [O]	*2008*	**100%**	12/2008
	2007	100%	12/2007
	2006	100%	80% (Unmet)
	2005	100%	100% (Met)
Data Source: Epi-X Application, Laboratory Response Network Laboratories, Public Health Emergency Preparedness & Response Cooperative Agreement recipients.			
Data Validation: Measure 1 - The Epi-X application is used to track how many reports are posted to the application annually, as well as how many states and major metropolitan areas have access to the application. This information is routinely analyzed through automated and manual procedures, to ensure it is accurate. Measures 2 - While CDC is developing objective measures that define CDC-compliant, standards-based electonic disease surveillance systems, half of the grantee recipients report use of Internet browser-based data entry and receipt of electronic laboratory results (ELR). Additionally, all LRN Labs use established protocols for telephone reporting and have the ability to usee a spreadsheet mechanism for reporting through the secure website.			
Cross Reference: *-4, 500-4; Measure 1 - HHS-2, 5, *-4, 500-4; Measure 2 - *-4, PART, 500-4			

Goal 4, Performance Measure 1:

Epi-X is CDC's secure web-based communications network for public health officials. In FY 2006, CDC increased the availability of Epi-X to 154 states and major metropolitan areas (all 50 states and 87 areas). At the end of FY 2006, 1,461 reports of disease outbreaks and other emerging health events had been posted on Epi–X. As more users participate in exchanging information via Epi-X, reports and use by public health authorities for the reporting of important public health events will increase.

Goal 4, Performance Measure 2:

Currently, all LRN labs can use established protocols for telephone reporting and, in addition, can use an interim spreadsheet mechanism for reporting through the secure website. The LRN was unable to meet its target of 100% for electronic reporting by the end of FY 2006. LRN laboratories faced a variety of challenges associated with the deployment of the software solution, Results Messenger version 2. Several issues delayed individual labs from installing the new software, including limited resources, labs lacking required hardware, and security issues associated with installing new hardware. Also, some labs have opted to forgo the installation of Results Messenger in favor of installing LIMS-compliant systems for reporting laboratory testing results to CDC.

INVESTIGATION

PREPAREDNESS GOAL 5: DECREASE THE TIME TO IDENTIFY CAUSES, RISK FACTORS, AND APPROPRIATE INTERVENTIONS FOR THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.			
Measure	**FY**	**Target**	**Result**
1. Increase the number of CDC professionals that are trained responders in the field.	*2006*	250	305 (Exceeded)
	2005	150	97 (Unmet)
2. Number of quarantine stations that are fully staffed with public health professionals who are preparedness to respond appropriately when needed.	*2008*	**Up to 25**	12/2008
	2007	Up to 25	12/2007
	2006	20	18 (Unmet)
	2005	Baseline	10
3. By 2010, the Quarantine Stations will reduce the time needed from a triggering biosurveillance event (notification of an international or interstate traveler who traveled while infectious with a quarantinable disease or other infectious disease of public health importance) to initiate event-specific standard operating procedures (e.g., isolation, quarantine, contact notification) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance.	Targets Under Development		
4. By 2010, CDC's epidemiology system will reduce the time to initiate, coordinate and resolve investigations to identify causes, risk factors and recommended interventions. [O]	Targets Under Development		
Data Source: Measure 1 - CDC's Field Services Office. Measure 2 - The Quarantine Station Rating System developed by the Infrastructure workgroup in DGMQ.			
Data Validation: Measure 1 – CDC's Field Services Office has developed training curriculum for all emergency responder staff. This curriculum was coordinated with CDC's Office of Workforce and Career Development, as well as CDC's Training and Education Goals and is continuously being validated and revised to meet the needs of CDC's emergency responder staff. The number of responders participating in these training courses is being tracked manually as well as through the web-based system that administers the online courses. Course evaluations are conducted after each training session (classroom and web-based) to determine the effectiveness of the course and identify areas for improvement. Measure 2 – An Excel workbook is the tool that is to be utilized by each of the CDC Quarantine Stations to evaluate their infrastructure and operational readiness. It is comprised of eight sheets that correspond to the tabs at the bottom of the screen in Excel: Staffing; Office Space; Office Equipment; Office Furniture; HIR (Holding/Isolation Room); Office Supplies; Medical Equipment & Supplies; Transportation. Each of these sheets has lists of items and resources (including staff) that one will mark with an "X," "NA" or leave blank to indicate the current status of this resource at the Quarantine Station. The QS Rating System document explains how the system works, and describes the meaning of terms, such as C (critical), N (necessary) NR (needed but not rated), and the Holding/Isolation Room levels - (1,2,3,4).			
Cross Reference: Measure 1 - *-1, 500-4; Measure 2 - 4 – HHS-2, PART, 500-4			

Goal 5, Performance Measure 1:

CDC's Field Services Office initiated a policy outlining the Public Health Readiness Field Program (PHRFP) describing placement, management, training and funding of field staff positions. An initial step developed the training to prepare new emergency response field staff for responsibilities in the field. Discipline specific competency-based guidelines have been established. A two-week course basic training curriculum ("boot camp") was developed for all emergency response staff. The training plan and curriculum were coordinated with CDC training goals and were integrated into CDC's Office of Workforce and Career Development.

In FY 2006, two course offerings were held in Anniston, AL at the FEMA Noble Trainings Center. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

Goal 5, Performance Measure 2:

Rebuilding the Quarantine System is necessary to protect the United States from international biological threats, both natural and intentional. Quarantine Station expansion and enhancement will improve the systematic collection, analysis, interpretation, and dissemination of data related to public health events at U.S. ports of entry. An expanded and enhanced quarantine system includes not only increasing CDC's physical presence at U.S. ports of entry, but also staffing each station with a multidisciplinary team of quarantine medical officers, public health advisors, epidemiologists, and information technicians, enhancing the stations' links to a global network for international traveler disease surveillance, increasing preparedness and response at ports of entry, and expanding collaboration and partnership activities with state and local agencies.

Goal 5, Performance Measure 3:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

Goal 5, Performance Measure 4:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to implement prevention interventions, decrease the time to classify health issues as terrorism or naturally occurring, and decrease the time to identify risk factors and causes of urgent public health events. These time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

CONTROL

GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.			
Measure	**FY**	**Target**	**Result**
1. Expand and enhance the Health Alert Network's (HAN) ability to rapidly provide access to public health guidelines, best practices, and information on the effectiveness of public health interventions.	*2008*	**a) 80% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis** **c) 85% of state grantees will have a protocol for testing and documenting send/receive capabilities**	12/2008
	2007	a) 75% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis c) 80% of state grantees will have a protocol for testing and documenting send/receive capabilities	12/2007
	2006	a) 70% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis. b) N/A c) 75% of state grantees will have a protocol for testing and documenting send/receive capabilities d) N/A	a) 58% of Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Unmet) b) N/A c) 12/2007 d) N/A
	2005	a) 65% of state and 35% of local health departments will acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 65% of state grantees will have communication established with identified, key stakeholders c) 60% of state grantees will have a protocol for testing and documenting send/receive capabilities d) Establish interoperable wireless redundant communication systems in 55% of state health departments	a) 57% of Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Unmet) b) 97% (Exceeded) c) 60% (Met) d) 98% (Exceeded)
	2004	a) 60% of states and 25% of local health departments will acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 50% of state grantees will have communication established with identified, key stakeholders c) 50% of state grantees will have a protocol for testing and documenting send/receive capabilities d) Establish interoperable wireless redundant communication systems in 40% of state health departments	a – d) Unmet
2. 100% of state public health agencies are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC. [O]	*2008*	**90% prepared**	12/2008
	2007	90% prepared	12/2007
	2006	80% prepared	70% (Unmet)
	2005	70% prepared	76% (Exceeded)
	2004	60% prepared	72% (Exceeded)

GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.			
Measure	**FY**	**Target**	**Result**
3. Number of treatments/prophylaxis for the appropriate response to known terrorist threats or public health emergencies for chemical, biological, radiological and nuclear threats in millions. [O]	*2008*	**2.3, 60, 0.17**	12/2008
	2003	Baseline	.2, 1.4, .4
4. The number of successful annual exercises that test response to multiple events with a 12-hour response time. [O]	*2008*	**1**	12/2008
	2007	1	12/2007
	2006	1	1 (Met)
	2005	Baseline	1
5. Number of trained and ready Technical Advisory Response Units (TARU) for response to multiple events.	*2008*	**9**	12/2008
	2007	7	12/2007
	2006	6	6 (Met)
	2005	Baseline	5
6. Percentage of inventory discrepancies that are reduced by using quality inventory management systems. [O]	*2008*	**<5%**	12/2008
	2007	<5%	12/2007
	2006	<5%	0.33% (Exceeded)
	2005	Establish Baseline	6 % (Met)
7. By 2010, CDC's response operations system will decrease the time from event to actions that will minimize morbidity and mortality. [O]	Targets Under Development		
Data Source: Measure 1- HAN, CDC's Division of the Strategic National Stockpile (SNS); Measure 2 - Completed SNS Assessment Tools, based on criteria outlined in A Guide for Preparedness, V 10.00.; Measures 3, 4, 5, 6 – DSNS.			
Data Validation: Measure 1– At CDC, HAN is maintained by the National Center for Public Health Informatics (NCPHI). The data that passes through and is captured in HAN is frequently validated by NCPHI staff. Measure 2 – The SNS program maintains a staff Program Services Consultants who provide ongoing technical advice and training assistance to Public health Emergency Preparedness & Response grantees. The consultants also assess the grantee's level of preparedness to receive, distribute and dispense SNS assets. These services improve the grantee's ability to receive, stage, store and distribute the SNS materiel. Measures 3, 4, 5, 6, – DSNS maintains internal tracking systems to monitor its ability to deliver critical medical assets in a national emergency. A new Stockpile Resource Planning (SRP) database and inventory system is used to track and validate stockpiled material.			
Cross Reference: Measure 1 - *-4, 5, HHS-2, PART, 500-4; Measure 2 - HHS-2, 4, 5, PART, PAR, 500-4; Measure 3, 4, 5, 6, 7 – HHS-2, PART, 500-4			

Goal 6, Performance Measure 1:

Currently, three basic building blocks for routine and emergency information dissemination are being completed nationwide by HAN:

- Continuous high-speed Internet connectivity to support rapid information access.
- Broadcast capacity to support emergency communication.
- Establishment of redundant communications.

To obtain the status of performance for this measure, CDC's National Center for Public Health Informatics sent a test message to the 62 Bioterrorism Cooperative Agreement grantees. Of those, 58 percent responded within 30 minutes. Overall, 85 percent responded. CDC also used survey results of the 50 states, seven pacific jurisdictions, and four cities/districts for measuring communication established with identified key stakeholders and establishment of interoperable wireless redundant communication systems.

Plans for coming years include continued technical assistance and network testing to ensure timely message translation, dissemination, local response, and feedback. Note that targets b) and d) will be retired after data are reported for FY 2005.

Goal 6, Performance Measure 2:

CDC describes 12 functions of SNS Preparedness required for the effective management and use of deployed SNS materiel. Based on these functions, grantees are required to develop SNS Preparedness Plans detailing the performance of these functions during an emergency. In an effort to enhance grantee SNS preparedness planning efforts, CDC maintains a staff of program service consultants who provide ongoing technical advice and training assistance to grantees. These consultants also assess the grantees' level of preparedness to receive, distribute and dispense SNS assets. This measure is a CDC challenge. Many jurisdictions lack proper facilities to receive the 50-ton package of SNS material. However, CDC provides technical assistance, education and training to improve the ability of states to receive stage, store and distribute the SNS material. In FY 2006, CDC is at 70 percent, not meeting its target of 80 percent.

Goal 6, Performance Measures 3:

As a result of the PART process, CDC developed this long-term performance measure. CDC will grow and maintain treatment/prophylaxis capability for chemical, biological, radiological/nuclear threats. CDC will report on the measure in FY 2008.

Goal 6, Performance Measures 4 - 5:

As a result of the PART process, CDC developed new performance measures. In FY 2006, CDC met its goal of conducting one annual exercise that tested response to multiple events within a 12-hour response time. CDC also met its goal of six trained and ready Technical Advisory Response Unites (TARU) for response to multiple events.

Goal 6, Performance Measure 6:

As a result of the PART process, CDC developed this performance measure to track inventory discrepancies. In FY 2006, inventory discrepancies were reduced to 0.33 percent, exceeding the target of less than 5 percent.

Goal 6, Performance Measure 7:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to identify events of national public health importance, initiate investigations, determine causes and risk factors, identify and implement effective countermeasures and provide timely and accurate communications with the public.

RECOVER

Preparedness Goals seven (Decrease the time needed to restore health services and environmental safety to pre-event levels) and eight (Improve the long-term follow-up provided to those affected by threats to the public's health) do not currently have supporting performance measures.

IMPROVE

PREPAREDNESS GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATION FROM AFTER-ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH.			
Measure	**FY**	**Target**	**Result**
1. 100% of state public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.	*2008*	**100%**	12/2008
	2007	100%	12/2007
	2006	100%	94% (Unmet)
	2005	25%	94% of state public health agencies have developed plans for at least one priority agent (Met)
2. Increase the percentage of the TPER allocation for which budget execution matches strategic funding priorities.	Targets Under Development		

PREPAREDNESS GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATION FROM AFTER-ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH.			
Measure	**FY**	**Target**	**Result**
3. Improve the on-time achievement of individual project milestones for Epidemiology, Laboratories and Emergency Response.	*2008*	**93%**	12/2008
	2007	90%	12/2007
	2006	Baseline	87%
4. Achieve progressive improvements in the quality of projects submitted for TPER Upgrading CDC Capacity funding consideration.	*2008*	**78%**	12/2007
	2007	Baseline	74%
Data Source: Self-reported data as part of required progress reports.			
Data Validation: See Efficiency Measure Data Validation.			
Cross Reference: Measure 1 - HHS-2, PART, PAR, 500-4; Measures 2 – 4 - PART			

Goal 9, Performance Measure 1:

In order for state and local public health agencies to test their capabilities for responding to bioterrorism, chemical exposures, and other public health emergencies, CDC recommends that response plans be tested regularly by staff participation in exercises and simulation drills. Lessons learned from both responses to real events and annual exercises can help identify gaps in preparedness planning and should result in improved public health responses.

In FY 2006, 94 percent (47 of 50) of State health agencies exercised their plans for at least one priority agent. In future years, grantees will need to implement corrective actions within 90 days of identifying a deficiency through a drill, exercise, or real event. The FY 2006 - 2008 targets expect that 100 percent of grantees will meet requirements in these areas. In FY 2006, this measure was not met. However, future exercises, focusing on non-pharmacologic interventions and mass prophylaxis, will be closely monitored to ensure achievement of the 100 percent goal.

Goal 9, Performance Measure 2:

This measure reflects the need to ensure that budget execution matches strategic funding priorities. CDC is developing a decision-support process for linking budget formulation to the priorities identified in the preparedness goal action plan. This decision-support process will allow consideration of new initiatives, expansion or enhancement to existing projects, or the elimination of completed or out-dated projects.

Goal 9, Performance Measure 3:

All individual projects funded to upgrade CDC capacity must improve performance in order to achieve the long-term measures. Individual project performance is monitored continuously and can be summarized as the average time-appropriate achievement of milestones in the core functional areas.

Goal 9, Performance Measure 4:

The spending plan process maximizes efficiency by centralizing the project submission and review process, thereby allowing for the early identification of duplicative efforts. Project submissions include detailed workplans and timelines, and must include responses to standardized evaluation questions that are used to rate and select projects for funding. This process allows for the selection of projects that are most likely to achieve the objectives of upgrading some part of CDC's preparedness capacity, are not duplicative of each other, are well-specified and likely to succeed.

CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS

From FY 2003 to 2008, CDC/ATSDR reduced the total number of measures included in its performance plan by eight percent. The proportion of outcome measures to the total number of measures increased from 44 percent in FY 2003 to 48 percent in FY 2008. The FY 2008 Congressional Justification includes several specific changes from the FY 2007 Congressional Justification.

PART MEASURES

As a result of OMB's 2006 Program Assessment Rating Tool (PART) process, CDC added performance measures to the FY 2008 annual performance plans, many of which were enhancements upon previous GPRA measures.

In 2006, CDC had five programs reviewed through PART, resulting in a total of 43 new performance measures (four efficiency measures, 33 outcome measures and six output measures) were added to CDC's performance plan. CDC's 2006 PART programs include Injury Prevention and Control, Chronic Disease Prevention, Birth Defects and Developmental Disabilities, BioSurveillance and Upgrading CDC Capacity. To review the new measures, refer to the Detail of Performance Analysis sections.

PREPAREDNESS FRAMEWORK

In FY 2004, CDC developed a new framework to execute the agency's overarching preparedness goals. Following the establishment of this framework, CDC aligned its existing Terrorism performance measures to the appropriate preparedness goals within the new framework. For those goals for which current performance measures do not exist, CDC is leading an effort in coordination with OMB and HHS to develop new outcome-oriented measures. The performance information found in the Detail of Performance Analysis section reflects CDC's new framework for its preparedness goals.

EFFICIENCY MEASURES

Consistent with the PMA Standards for Success for Budget and Performance Integration, CDC "has at least one efficiency measure for all PART'ed programs." To meet this requirement, CDC developed and OMB approved a new efficiency measure for the Immunization, Domestic HIV/AIDS prevention, STD/TB and State and Local Preparedness programs. The Breast & Cervical Cancer and Diabetes' programs had efficiency measures which were approved by OMB as well. However, these measures were subsumed into the new National Center for Chronic Disease Prevention and Health Promotion measure developed through PART. CDC had five programs reviewed through PART for the 2006 cycle, resulting in four new efficiency measures added to CDC's performance plan (Biosurveillance and Upgrading CDC Capacity programs have the same efficiency measure).

COORDINATING CENTER FOR INFECTIOUS DISEASES

The Coordinating Center for Infectious Diseases has been reorganized into four Centers and Budget Activities: Immunization and Respiratory Diseases; HIV/AIDS, Viral Hepatitis, STD and TB Prevention; Zoonotic, Vector-Borne, and Enteric Diseases; and Preparedness, Detection and Control of Infectious Diseases. While the goals and measures remain the same, several have been moved based on the new budget structure.

CHANGE TABLE

Program Activity	Goal	Previous Measure	Change and Explanation
Domestic HIV/AIDS Prevention	Efficiency Measure	Increase the number of states using confidential name-based HIV reporting systems.	*Approved by OMB May, 2006* - Improve the accuracy of the portrayal of the U.S. HIV epidemic in national reports by increasing the number of states using confidential name-based HIV reporting methods with level funding, thereby enabling CDC to report standardized HIV data from a larger number of jurisdictions.
STD/TB Prevention	Efficiency Measure	Reduce division-level printing costs by offering updated tuberculosis (TB) educational and training materials on CD ROM rather than printed materials.	*OMB Approved May, 2006* - Reduce the amount of time it takes to award grantees' unobligated funds by meeting the Procurement and Grant Office's (PGO) key performance targets without increased funding.
Immunization	Efficiency Measure	Establish a target range for VFC and Section 317 funds requested by grantees for assessing vaccination coverage levels and providing feedback (AFIX) in healthcare provider office and clinic settings, and continue to monitor progress toward achieving the AFIX cost range.	*OMB Approved May, 2006* - Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S.
Breast and Cervical Cancer	Efficiency Measure	*Approved by OMB May, 2006* – Improve the volume and quality of screening/diagnostic services by increasing the percent of appropriated funds awarded above baseline to the most efficient and effective grantees.	This measure is no longer displayed in the budget submission due to the development of a Center-wide PART efficiency measure.
Diabetes	Efficiency Measure	*Approved by OMB May, 2006* Improve technical assistance to grantees by increasing the proportion of Program Development Branch staff time dedicated to providing technical assistance to grantees instead of performing administrative management duties.	This measure is no longer displayed in the budget submission due to the development of a Center-wide PART efficiency measure.

Program Activity	Goal	Previous Measure	Change and Explanation
State and Local Preparedness	Efficiency Measure	N/A	Decrease the amount of time it takes the Division of State and Local Readiness (DSLR) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by providing appropriate tools and functionality in the DSLR Management Information System (MIS)
Chronic Disease Prevention and Health Promotion	Efficiency Measure	N/A	*New PART Measure:* Number of financial actions (such as project carryover funds requests from grantees and grantee project re-budgetings) that delay the implementation of grantee and partners' activities.
Birth Defects and Developmental Disabilities	Efficiency Measure	N/A	*New PART Measure:* Increase the percent of competitive (new) cooperative agreements/grants that are processed in less than or equal to 176 days (excluding extramural research).
Injury Prevention and Control	Efficiency Measure	N/A	*New PART Measure:* Reduce the amount of time to submit funding packages for non-research funding opportunities to CDC's Procurement and Grants Office.
Biosurveillance and Upgrading CDC Capacity	Efficiency Measure	N/A	*New PART Measure:* Decrease annual costs for personnel and materials development with the development and continuous improvement to the budget and performance integration information system tools.
Health Marketing	CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.	Refer to change section.	*New overarching goal has a broader scope to better reflect the program's mission:* CDC will maintain and improve its website and electronic communications to provide science-based health information to health care professionals, CDC partners and the American public.
	CDC will maintain and improve its website and electronic communications to provide science-based health information to health care professionals, CDC partners and the American public.	Increase the number of interventions adopted by state health officers that were recommended by the *Community Guide*.	*New measure has a broader scope to better reflect the program's mission:* Increase access and utilization of CDC.gov by public, partners, and other health care professionals.

Program Activity	Goal	Previous Measure	Change and Explanation
	Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies; AND prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.	Expand frontline public health practitioners' access to Internet-based, CDC-approved public health practice guidelines, scientific/disease reference images, health and medical data, and information on the effectiveness of public health interventions (retiring after FY 2006). *Targets based on the number of images in the Public Health Image Library.*	*Replacing retired measure with one which better reflects the intent of the overarching goal:* Increase the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools designed to provide information, educational materials, and real-time alerts as measured by the number of subscribers to Epi-X, HAN and national public health radio networks.
Environmental Health	Determine human health effects associated with environmental exposures	Assess exposure of the U.S. population to environmental chemicals, including nutritional indicators.	*New 2005 PART measure – reworded:* Number of environmental chemicals, including nutritional indicators, that are assessed for exposure of the U.S. population.
	Prevent or Reduce Illnesses, Injury, and Death Related to Environmental Risk Factors.	Reduce asthma hospitalizations in states funded by CDC to implement comprehensive asthma control programs.	*New 2005 PART measure – reworded:* Percentage reduction in asthma hospitalizations in states funded for partial and full implementation per 100,000 people.
		Reduce the number of children with elevated BLLs.	*New 2005 PART measure – reworded:* Number of children under age 6 with elevated blood lead levels.
		Increase the capacity of state, local and tribal agencies for which CDC provides assistance to prevent the spread of outbreaks from food- and water-borne illness.	*New 2005 PART measure – reworded:* Percentage increase in the capacity of state health departments to anticipate and prevent the spread of illness/disease outbreaks from food– and water-borne illness.
Global Health: **Global Immunizations**	Work with global partners to reduce the cumulative global measles-related mortality by 90% compared with 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas.	By 2015, reduce by 90 percent the cumulative global measles-related mortality compared with 2000 estimates (Baseline: 777,000 deaths).	*New 2005 PART measure – reworded:* Number of global measles-related deaths.
		Eliminate measles transmission in all 47 countries of the Americas.	*New 2005 PART measure – reworded:* Number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission.

Program Activity	Goal	Previous Measure	Change and Explanation
Office of Minority Health	N/A	N/A	*New Goal:* Support and strengthen capacity development strategies of existing National and Regional Minority Organizations.
	Support and strengthen capacity development strategies of existing National and Regional Minority Organizations.	N/A	*New Measure:* Increase the number of national and regional public health collaborations with public health agencies/organizations serving minority communities via the delivery of culturally-proficient and linguistically-appropriate public health services and by developing, promoting, and marketing health promotion and professional training and educational programs and materials.
		N/A	*New Measure:* Identify program and organizational infrastructure needs (i.e., policy analysis, program assessment and development, and evaluation) of public health agencies/organizations serving minority communities and provide technical assistance to improve the health status and access to programs for racial and ethnic minority populations.

SUPPLEMENTAL MATERIAL

STATE AND FORMULA GRANT PROGRAMS

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2008 DISCRETIONARY STATE/FORMULA GRANTS
CFDA NUMBER/PROGRAM NAME: PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE

State/Territory	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Alabama	$1,561,826	$1,561,826	$0	($1,561,826)
Alaska	$337,787	$337,787	$0	($337,787)
Arizona	$1,179,532	$1,179,532	$0	($1,179,532)
Arkansas	$879,295	$879,295	$0	($879,295)
California	$6,820,205	$6,820,205	$0	($6,820,205)
Colorado	$1,220,128	$1,220,128	$0	($1,220,128)
Connecticut	$1,422,390	$1,422,390	$0	($1,422,390)
Delaware	$184,263	$184,263	$0	($184,263)
District of Columbia	$751,917	$751,917	$0	($751,917)
Florida	$2,978,945	$2,978,945	$0	($2,978,945)
Georgia	$3,025,723	$3,025,723	$0	($3,025,723)
Hawaii	$762,579	$762,579	$0	($762,579)
Idaho	$365,501	$365,501	$0	($365,501)
Illinois	$2,350,067	$2,350,067	$0	($2,350,067)
Indiana	$1,659,205	$1,659,205	$0	($1,659,205)
Iowa	$1,079,949	$1,079,949	$0	($1,079,949)
Kansas	$895,862	$895,862	$0	($895,862)
Kentucky	$1,320,063	$1,320,063	$0	($1,320,063)
Louisiana	$2,838,802	$2,838,802	$0	($2,838,802)
Maine	$872,017	$872,017	$0	($872,017)
Maryland	$1,851,803	$1,851,803	$0	($1,851,803)
Massachusetts	$2,663,359	$2,663,359	$0	($2,663,359)
Michigan	$3,878,924	$3,878,924	$0	($3,878,924)
Minnesota	$2,474,018	$2,474,018	$0	($2,474,018)
Mississippi	$1,423,855	$1,423,855	$0	($1,423,855)
Missouri	$2,441,987	$2,441,987	$0	($2,441,987)
Montana	$645,459	$645,459	$0	($645,459)
Nebraska	$1,592,139	$1,592,139	$0	($1,592,139)
Nevada	$387,170	$387,170	$0	($387,170)
New Hampshire	$1,388,849	$1,388,849	$0	($1,388,849)
New Jersey	$2,843,269	$2,843,269	$0	($2,843,269)
New Mexico	$1,368,111	$1,368,111	$0	($1,368,111)
New York	$6,770,526	$6,770,526	$0	($6,770,526)
North Carolina	$2,694,665	$2,694,665	$0	($2,694,665)
North Dakota	$250,692	$250,692	$0	($250,692)

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2008 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER/PROGRAM NAME: PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE				
State/Territory	**FY 2006 Actual**	**FY 2007 CR**	**FY 2008 Budget**	**FY 2008 +/- FY 2007**
Ohio	$4,446,617	$4,446,617	$0	($4,446,617)
Oklahoma	$927,095	$927,095	$0	($927,095)
Oregon	$716,429	$716,429	$0	($716,429)
Pennsylvania	$4,685,903	$4,685,903	$0	($4,685,903)
Rhode Island	$465,364	$465,364	$0	($465,364)
South Carolina	$1,210,792	$1,210,792	$0	($1,210,792)
South Dakota	$229,317	$229,317	$0	($229,317)
Tennessee	$1,602,849	$1,602,849	$0	($1,602,849)
Texas	$4,043,849	$4,043,849	$0	($4,043,849)
Utah	$942,017	$942,017	$0	($942,017)
Vermont	$267,593	$267,593	$0	($267,593)
Virginia	$2,009,185	$2,009,185	$0	($2,009,185)
Washington	$1,007,626	$1,007,626	$0	($1,007,626)
West Virginia	$878,445	$878,445	$0	($878,445)
Wisconsin	$1,923,229	1,923,229	$0	($1,923,229)
Wyoming	$222,559	222,559	$0	($222,559)
Subtotal	**$90,759,751**	**$90,759,751**	**$0**	**($90,759,751)**
Indian Tribes	$57,512	$57,512	$0	($57,512)
Migrant Program	$0	$0	$0	$0
American Samoa	$51,808	$51,808	$0	($51,808)
Guam	$213,785	$213,785	$0	($213,785)
Marshall Islands	$0	$25,838	$0	($25,838)
Micronesia	$62,938	$62,938	$0	($62,938)
Northern Mariana Islands	$39,505	$39,505	$0	($39,505)
Palau	$20,567	$20,567	$0	($20,567)
Puerto Rico	$1,536,725	$1,536,725	$0	($1,536,725)
Virgin Islands	$169,056	$169,056	$0	($169,056)
Subtotal	**$2,151,896**	**$2,151,896**	**$0**	**($2,151,896)**
Total States/Territories	**$92,911,647**	**$92,937,485**	**$0**	**($92,937,485)**
Assessment Initiative (CCHIS)	$2,388,609	$2,388,609	$0	($2,388,609)
Program Management, Accountability, and Evaluation	$3,631,744	$3,673,906	$0	($3,673,906)
State Penalties	-	-	-	-
Contingency Fund	-	-	-	-
Other Adjustments (specify)	-	-	-	-
Subtotal Adjustments	**$6,020,353**	**$6,062,515**	**$0**	**($6,062,515)**
TOTAL	**$98,932,000**	**$99,000,000**	**$0**	**($99,000,000)**

VACCINES FOR CHILDREN STATE-BY-STATE TABLE

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2008 MANDATORY STATE/FORMULA GRANTS VACCINES FOR CHILDREN PROGRAM				
State/Territory/Grantee	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Alabama	$31,993,366	$47,055,869	$45,956,000	($1,099,869)
Alaska	$6,772,224	$9,880,470	$9,607,872	($272,598)
Arizona	$53,299,116	$78,403,626	$76,576,890	($1,826,736)
Arkansas	$18,806,274	$27,659,986	$27,013,316	($646,670)
California	$219,195,776	$322,715,141	$315,339,408	($7,375,732)
Colorado	$21,871,530	$32,103,931	$31,319,890	($784,041)
Connecticut	$13,452,844	$19,629,743	$19,089,450	($540,293)
Delaware	$5,762,561	$8,404,369	$8,170,906	($233,463)
District of Columbia	$5,787,923	$8,359,219	$8,083,944	($275,274)
Florida	$94,187,718	$138,529,911	$135,291,198	($3,238,714)
Georgia	$73,580,732	$108,296,746	$105,803,999	($2,492,746)
Hawaii	$5,453,732	$7,775,881	$7,466,510	($309,370)
Idaho	$9,018,211	$13,239,222	$12,916,894	($322,327)
Illinois	$55,522,373	$81,683,282	$79,784,925	($1,898,358)
Indiana	$30,728,224	$45,082,758	$43,970,603	($1,112,154)
Iowa	$12,748,657	$18,673,988	$18,197,608	($476,380)
Kansas	$13,819,693	$20,253,529	$19,742,443	($511,085)
Kentucky	$18,245,259	$26,832,701	$26,204,253	($628,448)
Louisiana	$32,525,001	$47,802,240	$46,666,439	($1,135,801)
Maine	$6,929,889	$10,039,132	$9,724,753	($314,379)
Maryland	$25,739,421	$37,813,938	$36,907,407	($906,531)
Massachusetts	$29,716,448	$43,636,768	$42,580,316	($1,056,453)
Michigan	$55,425,441	$81,474,972	$79,547,304	($1,927,668)
Minnesota	$18,484,952	$27,134,332	$26,472,366	($661,966)
Mississippi	$21,069,213	$31,005,300	$30,289,267	($716,034)
Missouri	$27,273,775	$40,094,889	$39,147,637	($947,252)
Montana	$4,910,250	$7,182,682	$6,994,355	($188,327)
Nebraska	$9,270,267	$13,619,899	$13,293,848	($326,051)
Nevada	$18,088,069	$26,530,825	$25,872,687	($658,138)
New Hampshire	$5,983,713	$8,729,932	$8,489,012	($240,920)
New Jersey	$41,665,607	$61,228,456	$59,769,583	($1,458,872)
New Mexico	$19,716,377	$28,934,482	$28,224,706	($709,777)
New York	$43,876,350	$64,123,948	$62,412,278	($1,711,669)
North Carolina	$40,167,469	$58,996,059	$57,574,323	($1,421,736)
North Dakota	$3,134,198	$4,578,429	$4,455,115	($123,314)

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2008 MANDATORY STATE/FORMULA GRANTS VACCINES FOR CHILDREN PROGRAM				
State/Territory/Grantee	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/ FY 2007
Ohio	$42,725,845	$62,898,403	$61,457,972	($1,440,432)
Oklahoma	$35,207,845	$51,711,790	$50,465,696	($1,246,094)
Oregon	$22,811,160	$33,461,917	$32,633,645	($828,272)
Pennsylvania	$37,936,573	$55,486,706	$54,028,383	($1,458,323)
Rhode Island	$7,084,568	$10,350,476	$10,072,409	($278,068)
South Carolina	$27,393,627	$40,193,208	$39,203,128	($990,081)
South Dakota	$5,596,267	$8,194,820	$7,984,471	($210,350)
Tennessee	$33,810,254	$49,700,774	$48,524,851	($1,175,923)
Texas	$182,673,808	$268,930,020	$262,775,790	($6,154,230)
Utah	$18,400,600	$26,993,085	$26,325,488	($667,597)
Vermont	$4,687,116	$6,782,151	$6,565,575	($216,576)
Virginia	$26,169,053	$38,456,811	$37,540,957	($915,854)
Washington	$36,823,713	$53,791,976	$52,343,146	($1,448,830)
West Virginia	$9,372,560	$13,740,453	$13,396,041	($344,412)
Wisconsin	$21,068,453	$30,964,325	$30,228,528	($735,798)
Wyoming	$3,659,041	$5,318,267	$5,160,970	($157,297)
Indian Tribes	-	-	-	-
Migrant Program	-	-	-	-
Chicago	$30,791,684	$45,158,964	$44,036,122	($1,122,842)
Houston	$823,091	$1,081,514	$989,122	($92,391)
New York City	$61,932,974	$91,046,211	$88,894,805	($2,151,406)
Philadelphia	$16,384,722	$23,942,149	$23,301,162	($640,987)
San Antonio	$18,064,594	$26,549,301	$25,918,286	($631,015)
American Samoa	$887,460	$1,302,445	$1,270,530	($31,915)
Guam	$1,727,117	$2,517,687	$2,447,112	($70,575)
Marshall Islands	-	-	-	-
Micronesia	-	-	-	-
Northern Mariana Islands	$652,145	$934,807	$900,288	($34,519)
Palau	-	-	-	-
Puerto Rico	$20,924,540	$30,617,020	$29,818,823	($798,197)
Virgin Islands	$2,008,011	$2,861,064	$2,746,194	($114,870)
Total States/Cities/Territories	**$1,763,839,474**	**$2,590,493,000**	**$2,527,987,000**	**($62,506,000)**
Technical Assistance	-	-	-	-
State Penalties	-	-	-	-
Contingency Fund	-	-	-	-
Other Adjustments [1]	$309,273,526	$314,837,000	$233,970,000	($80,867,000)
Subtotal Adjustments	**$210,455,526**	**$314,837,000**	**$233,970,000**	**($80,867,000)**
Total Resources [2]	**$1,974,295,000**	**$2,905,330,000**	**$2,761,957,000**	**($143,373,000)**

[1] Adjustments include costs associated with vaccines stockpile purchases, storage and rotations, special projects, and program support services.

[2] Approximately $99 million of funds that were apportioned in FY 2006 were carried over to FY 2007, mainly due to some pediatric vaccine stockpile purchases being delayed to FY 2007.

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE) [1]

	FY 2006 Actual	FY 2007 CR	FY 2008 Budget
Infectious Diseases	2,534	2,592	2,677
Health Promotion [2]	1,013	1,051	1,094
Health Information and Service	711	714	738
Environmental Health and Injury Prevention	490	495	513
Occupational Safety and Health	1,150	1,121	1,161
Global Health	78	92	95
Public Health Research	6	6	6
Public Health Improvement and Leadership	797	797	825
Preventive Health & Health Services Block Grant (PHHSBG) [2]	8	8	0
Business Services Support	895	895	926
Terrorism [3]	499	722	930
Agency for Toxic Substances and Disease Registry	330	330	330
TOTAL, CDC/ATSDR FTE	**8,510**	**8,823**	**9,295**

[1] FTE levels across CDC are projected to increase due to processing backlogged hiring actions in light of relief from hiring restrictions in FY 2006.

[2] The PHHSBG is eliminated in the FY 2008 Budget. As a result, FTE levels for Health Promotion include those from PHHSBG in FY 2008.

[3] FTE levels for Terrorism include proposed increases for assigning additional FTEs to Pandemic Influenza Planning and Preparedness which will require hiring scientific and public health personnel in FY 2007 to ensure CDC is able to effectively carry out its role in domestic and global preparedness. Terrorism preparedness activities and the Strategic National Stockpile (SNS) program are areas where a stable workforce is essential. Conversion of contractor SNS staff to federal employees to support state and local preparedness efforts is underway. Refer to the "New Positions Requested" exhibit for detailed numbers.

DETAIL OF POSITIONS

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
PROGRAM ADMINISTRATION
DETAIL OF POSITIONS

	FY 2006 Actual	FY 2007 CR	FY 2008 Budget
Executive Level			
Executive level I	-	-	-
Executive level II	-	-	-
Executive level III	-	-	-
Executive level IV	-	-	-
Executive level V	-	-	-
Subtotal	**-**	**-**	**-**
Total-Executive Level Salary	**-**	**-**	**-**
Total - SES	***31***	***31***	***31***
Total - SES Salary	**$4,695,841**	**$4,822,629**	**$4,967,308**
GS-15	478	478	478
GS-14	1,275	1,275	1,275
GS-13	2,045	2,045	2,045
GS-12	1,090	1,090	1,090
GS-11	693	693	693
GS-10	53	53	53
GS-9	437	437	437
GS-8	75	75	75
GS-7	397	397	397
GS-6	68	68	68
GS-5	73	73	73
GS-4	48	48	48
GS-3	30	30	30
GS-2	1	1	1
GS-1	0	0	0
Subtotal	***6,763***	***6,763***	***6,763***
Total - GS Salary	**$548,932,489**	**$561,009,003**	**$577,839,273**
Average GS grade	11.9	11.9	11.9
Average GS salary	81,167	82,953	85,441
Average Special Pay Categories			
Average Comm. Corps Salary[1]	95,659	98,242	101,189
Average Wage Grade Salary	49,858	50,954	52,483

[1] Includes special pays and allowances.

NEW POSITIONS REQUESTED

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
NEW POSITIONS REQUESTED

	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Terrorism - Strategic National Stockpile	80	110	30
Terrorism - Pandemic Influenza Planning and Preparedness	165	125	(40)
Total	**245**	**235**	**(10)**

PERFORMANCE BUDGET CROSSWALK

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
PERFORMANCE BUDGET CROSSWALK
(DOLLARS IN THOUSANDS)

Performance Program Area (PPA)	Budget Activity	FY 2006 Actuals	FY 2007 CR	FY 2008 Budget
Infectious Diseases	Infectious Diseases	$1,695,156	$1,658,626	$1,794,368
Health Promotion	Health Promotion	$958,025	$958,687	$958,732
Health Information and Services	Health Information and Services	$218,905	$218,966	$243,496
Environmental Health and Injury and Prevention	Environmental Health and Injury and Prevention	$287,474	$287,674	$287,674
Occupational Safety and Health	Occupational Safety and Health	$262,883	$252,999	$252,998
Global Health	Global Health	$379,624	$310,420	$379,719
Public Health Research	Public Health Research	$31,000	$31,000	$31,000
Public Health Improvement and Leadership	Public Health Improvement and Leadership	$264,106	$189,236	$190,412
Preventive Health & Health Services Block Grant	Preventive Health & Health Services Block Grant	$98,932	$99,000	$0
Buildings and Facilities	Buildings and Facilities	$158,291	$133,638	$20,000
Business Services Support	Business Services Support	$317,576	$317,781	$319,877
Agency for Toxic Substance and Disease Registry	Agency for Toxic Substance and Disease Registry	$74,905	$74,905	$75,004
Terrorism	Terrorism	$1,631,173	$1,543,947	$1,504,375
	Total Request	**$6,378,050**	**$6,076,879**	**$6,057,655**

SUMMARY OF FULL COST

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
SUMMARY OF FULL COST
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
INFECTIOUS DISEASES[1]	$3,647.0	$3,976.3	$4,502.9
Immunization and Respiratory Diseases[1]	$2,550.7	$3,443.8	$3,346.3
Goal 1[1]	$1,252.3	$1,673.4	$1,620.6
Measure 1	$980.1	$1,306.1	$1,264.8
Measure 2	$136.1	$183.7	$177.9
Measure 3	$136.1	$183.7	$177.9
Goal 2[1]	$1,252.3	$1,673.4	$1,620.6
Measure 1	$1,252.3	$1,673.4	$1,620.6
Goal 3	$17.3	$37.7	$40.9
Measure 1	$8.6	$18.8	$20.5
Measure 2	$8.6	$18.8	$20.5
Goal 4	$11.5	$43.1	$46.8
Measure 1	$11.5	$43.1	$46.8
Goal 5[2]	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Goal 6	$17.3	$16.2	$17.5
Measure 1	$17.3	$16.2	$17.5
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	$1,052.2	$1,038.4	$1,112.9
HIV/AIDS, Research and Domestic	$471.7	$465.6	$543.8
Goal 1	$696.6	$687.4	$770.1
Measure 1	$458.0	$452.0	$529.6
Measure 2	$3.1	$3.1	$3.1
Goal 2	$176.7	$174.4	$177.6
Measure 1	$34.3	$33.8	$31.4
Goal 3	$140.4	$138.5	$210.6
Measure 1	$106.0	$104.6	$131.2
Measure 2	$34.5	$34.0	$79.3
Goal 4	$30.6	$30.2	$30.6
Measure 1	$0.0	$0.0	$0.0
Goal 5	$124.0	$122.4	$125.0
Measure 1	$55.0	$54.2	$55.3
SexuallyTransmitted Diseases	$26.0	$25.7	$22.9
Goal 6	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Measure 2	N/A	N/A	N/A
Goal 7	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Measure 2	N/A	N/A	N/A
Goal 8	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Goal 9	$15.7	$15.4	$13.7
Measure 1	$4.9	$4.9	$4.3
Measure 2	$5.5	$5.4	$4.8
Measure 3	$5.2	$5.2	$4.6
Goal 10	$10.4	$10.2	$9.2
Measure 1	$7.4	$7.3	$6.5
Measure 2	$1.9	$1.9	$1.7
Measure 3	$1.1	$1.1	$1.0
Tuberculosis	$21.7	$21.4	$18.9
Goal 11	$21.7	$21.4	$18.9
Measure 1	$152.9	$150.9	$146.5
Measure 2	$15.4	$15.2	$12.2
Measure 3	$2.0	$1.9	$1.6
Measure 4	$4.3	$4.3	$3.4
Viral Hepatitis	$0.3	$0.3	$0.3
Goal 12	$0.3	$0.3	$0.3
Measure 1	N/A	N/A	N/A
Zoonotic, Vector-Borne, and Enteric Diseases	$44.0	$43.1	$43.6
Goal 1	$44.0	$43.1	$43.6
Measure 1	$21.1	$20.6	$20.9

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLARS IN MILLIONS) Performance Program Area	FY 2006	FY 2007	FY 2008
Preparedness, Detection, and Control of Infectious Diseases	$15.7	$15.2	$15.1
Goal 1	$1.2	$1.1	$1.1
Measure 1	N/A	N/A	N/A
Measure 2	N/A	N/A	N/A
Measure 3	$0.2	$0.2	$0.2
Goal 2	$14.6	$14.0	$14.0
Measure 1	N/A	N/A	N/A
Measure 2	$1.0	$1.0	$1.0
Goal 3[2]	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
HEALTH PROMOTION	$579.3	$690.8	$685.6
Chronic Disease Prevention and Health Promotion	$420.3	$540.3	$537.0
Goal 1	$32.8	N/A	N/A
Measure 1	$19.8	N/A	N/A
Measure 2	$13.0	N/A	N/A
Goal 2	$30.3	N/A	N/A
Measure 1	$30.3	N/A	N/A
Goal 3	$111.9	N/A	N/A
Measure 1	$55.6	N/A	N/A
Measure 2	$13.6	N/A	N/A
Measure 3	$14.2	N/A	N/A
Measure 4	$14.2	N/A	N/A
Measure 5	$14.2	N/A	N/A
Goal 4	$57.5	N/A	N/A
Measure 1	$22.9	N/A	N/A
Measure 2	$13.0	N/A	N/A
Measure 3	$10.5	N/A	N/A
Goal 5	$84.7	N/A	N/A
Measure 1	$84.7	N/A	N/A
Goal 6	$47.0	N/A	N/A
Measure 1	$36.5	N/A	N/A
Goal 7	$30.9	N/A	N/A
Measure 1	$15.5	N/A	N/A
Measure 2	$15.5	N/A	N/A
Goal 8	$25.3	N/A	N/A
Measure 1	$12.7	N/A	N/A
Measure 2	$12.7	N/A	N/A
New Goal 1	N/A	$245.4	$243.0
Measure 1	N/A	$47.4	$46.9
Measure 2	N/A	$47.4	$46.9
Measure 3	N/A	$62.7	$62.1
New Goal 2	N/A	$79.5	$76.6
Measure 1	N/A	$39.7	$38.3
Measure 2	N/A	$39.7	$38.3
New Goal 3	N/A	$64.8	$59.4
Measure 1	N/A	$32.4	$29.7
Measure 2	N/A	$32.4	$29.7
New Goal 4	N/A	$43.2	$42.8
Measure 1	N/A	$21.6	$21.4
Measure 2	N/A	$11.2	$11.0
Measure 3	N/A	$11.2	$11.0
New Goal 5	N/A	$47.4	$42.1
Measure 1	N/A	$7.0	$6.2
Measure 2	N/A	$33.5	$29.7
New Goal 6	N/A	$60.0	$73.2
Measure 1	N/A	$17.4	$17.3
Measure 2	N/A	$17.4	$17.3
Measure 3	N/A	$13.2	$13.1
Measure 4	N/A	$2.1	$6.9

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
SUMMARY OF FULL COST
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
Birth Defects, Developmental Disabilities, Disability and Health	$159.0	$150.5	$148.6
Goal 1	$68.4	$64.7	$63.9
Measure 1	$7.5	N/A	N/A
Measure 2	$5.5	N/A	N/A
Measure 3	$12.3	N/A	N/A
Measure 4	$6.0	$5.7	$5.6
Measure 5	$10.7	$10.1	$10.0
Measure 6	$0.4	$0.4	$0.4
Measure 7	$0.7	$0.6	$0.6
Goal 2	$90.6	$85.8	$84.7
Measure 1	$10.9	N/A	N/A
Measure 2	$23.6	N/A	N/A
Measure 3	$12.6	$11.9	$11.8
Measure 4	$2.5	$2.4	$2.4
Measure 5	$4.7	$4.5	$4.4
Measure 6	$4.6	$4.4	$4.3
HEALTH INFORMATION SERVICES	$187.6	$184.9	$181.7
Health Statistics	$155.1	$147.3	$141.9
Goal 1	$155.1	$147.3	$141.9
Measure 1	$131.8	$117.9	$113.5
Measure 2	N/A	N/A	N/A
Measure 3	$7.8	$7.4	$7.1
Measure 4	$7.8	$7.4	$7.1
Health Marketing	$32.5	$37.5	$39.8
Goal 1	$7.2	$11.7	$16.4
Measure 1	$7.2	$11.7	$16.4
Goal 2	$19.9	$18.8	$18.7
Measure 1	$9.9	N/A	N/A
Measure 2	$9.9	$18.8	$18.7
Goal 3	$5.4	$7.0	$4.7
Measure 1	$5.4	$7.0	$4.7
ENVIRONMENTAL HEALTH AND INJURY	$344.7	$334.6	$327.5
Environmental Health	$185.8	$180.1	$174.7
Goal 1	$76.2	$73.8	$71.6
Measure 1	$13.0	$12.6	$12.2
Measure 2	$7.4	$7.2	$7.0
Measure 3	$18.6	$18.0	$17.5
Measure 4	$5.6	$5.4	$5.2
Goal 2	$102.2	$99.0	$96.1
Measure 1	$39.0	$37.8	$36.7
Measure 2	$42.7	$41.4	$40.2
Measure 3	$3.7	$3.6	$3.5
Measure 4	$3.7	$3.6	$3.5
Goal 3	$7.4	$7.2	$7.0
Measure 1	$3.7	$3.6	$3.5
Injury Prevention and Control	$158.9	$154.5	$152.8
Goal 1	$30.2	$29.4	$29.0
Measure 1	$8.5	N/A	N/A
Measure 2	$0.6	$0.9	$0.9
Goal 2	$9.5	$9.3	$9.2
Measure 1	$1.1	N/A	N/A
Goal 3	$4.8	$4.6	$4.6
Measure 1	$1.5	N/A	N/A
Goal 4	$106.5	$103.5	$102.4
Measure 1	N/A	N/A	N/A
Measure 2	N/A	$2.3	N/A
Goal 5	$7.9	$7.7	$7.6
Measure 1	N/A	$3.1	$3.1
Measure 2	$0.6	$1.1	$1.1
Measure 3	$0.6	$1.1	$1.1

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
SUMMARY OF FULL COST
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
OCCUPATIONAL SAFETY AND HEALTH	$368.2	$345.4	$324.7
Occupational Safety and Health	$368.2	$345.4	$324.7
Goal 1	$276.1	$259.0	$243.5
Measure 1	$41.4	$38.9	$36.5
Measure 2	N/A	N/A	N/A
Measure 3	$187.8	N/A	N/A
Measure 4	$19.3	$18.1	$17.0
Measure 5	N/A	$194.3	$182.6
Goal 2	$92.0	$86.3	$81.2
Measure 1	$5.5	$5.2	N/A
Measure 2	$12.0	$11.2	$10.6
Measure 3	$11.0	$10.4	$9.7
Measure 4	$5.5	$5.2	N/A
Measure 5	N/A	N/A	N/A
Measure 6	N/A	N/A	N/A
GLOBAL HEALTH	$278.8	$227.8	$275.1
Global Health - GAP	$128.2	$104.8	$126.5
Goal 1	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Goal 2	$83.6	$68.3	$82.5
Measure 1	$10.0	$8.2	$9.9
Measure 2	$5.9	$4.8	$5.8
Measure 3	$7.5	$6.2	$7.4
Measure 4	$5.9	$4.8	$5.8
Goal 3	$44.6	$36.4	$44.0
Measure 1	$5.4	$4.4	$5.3
Measure 2	$3.1	$2.6	$3.1
Measure 3	$4.0	$3.3	$4.0
Measure 4	$3.1	$2.6	$3.1
Global Health - Immunization	$150.5	$123.0	$148.6
Goal 4	$105.9	$86.6	$104.5
Measure 1	$19.1	$14.7	$17.8
Measure 2	$20.1	$17.3	$20.9
Goal 5	$44.6	$36.4	$44.0
Measure 1	$5.8	$4.7	$5.7
Measure 2	$0.9	$0.7	$0.9
PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP	$46.1	$42.8	$37.1
Office of Minority Health	$2.8	$2.8	$2.8
Goal 1	$0.6	$0.6	$0.6
Measure 1	$0.1	$0.1	$0.1
Goal 2	$0.6	$0.6	$0.6
Measure 1	$0.1	$0.1	$0.1
Goal 3[2]	-	-	-
Measure 1	-	-	-
Goal 4	$1.5	$1.5	$1.5
Measure 1	$0.4	$0.4	$0.4
Measure 2	$0.4	$0.4	$0.4
Office of Workforce and Development	$43.3	$40.0	$34.3
Goal 1	$43.3	$40.0	$34.3
Measure 1	$38.9	$36.0	$30.9
Goal 2[2]	-	-	-
Measure 1	-	-	-

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
SUMMARY OF FULL COST
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT	$99.0	$99.0	-
TERRORISM	$1,474.6	$1,400.3	$1,358.6
Goal 2	$72.6	$69.0	$66.9
Measure 1	$0.7	$0.7	$0.7
Measure 2	$25.9	$24.6	$23.9
Measure 3	$25.9	$24.6	$23.9
Goal 3	$48.9	$46.5	$45.1
Measure 1	$5.0	$4.7	$4.6
Measure 2	$5.0	$4.7	$4.6
Measure 3	$3.9	$3.7	$3.6
Measure 4	$2.2	$2.1	$2.0
Measure 5	$2.2	$2.1	$2.0
Measure 6	$5.0	$4.7	$4.6
Goal 4	$7.9	$7.5	$7.3
Measure 1	$0.6	$0.6	$0.6
Measure 2	$4.2	$4.0	$3.9
Goal 5	$44.2	$42.0	$40.7
Measure 1	$0.4	N/A	N/A
Measure 2	$6.5	$6.1	$5.9
Measure 3	$6.5	$6.1	$5.9
Measure 4	$4.4	$4.2	$4.0
Goal 6	$500.5	$475.3	$461.1
Measure 1	$5.0	$4.8	$4.6
Measure 2	$5.0	$4.8	$4.6
Measure 3	N/A	N/A	$173.4
Measure 4	$30.0	$28.5	$27.7
Measure 5	$30.0	$28.5	$27.7
Measure 6	$188.2	$178.7	$173.4
Measure 7	$5.0	$4.8	$4.6
Goal 9	$800.5	$760.1	$737.5
Measure 1	$498.7	$473.6	$459.5
Measure 2	$4.8	$4.6	$4.4
Measure 3	$240.1	$228.0	$221.3
Measure 4	$37.6	$35.7	$34.7
Total	**$7,040.9**	**$7,866.1**	**$7,708.3**

[1] *Includes VFC funding.*

[2] *The activities covered by these goals & measures are funded by other areas within CDC.*

N/A signifies retired goals and measures or measures not reported in a fiscal years.

CDC's Full Cost estimates for FY 2006 – FY 2008 were estimated by adding program management cost to the budget activities across CDC using the All Purpose Table. Program management costs included CDC's Leadership & Management and Business Services Support activities as well as Buildings & Facilities activities. Program management costs were allocated, where appropriate, across performance program areas based on the proportion of total program level cost represented by each program and performance program area. The full cost of each performance program area was then distributed by performance measures. These distributions are based on professional judgments, supported to the extent possible by financial and other statistical data. In many cases, performance measures are aggregated in the distributions of cost because of the interdependence of the activities and goals represented by the measures. The cost distributions by performance measures are presented for "active" measures in a given year. That is, measures that are to be deleted are included only for the applicable year(s) before their deletion; new measures are included beginning with the first year in which performance data are expected.

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (2006)

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
FUNDING BY PROGRAM AND ORGANIZATION – FY 2006
(DOLLARS IN THOUSANDS)

	ATSDR	CCID[1]	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD[2]	OWCD	BSS	Total
Infectious Diseases		1,695,156											1,695,156
Health Promotion			958,025										958,025
Health Information and Service				218,905									218,905
Environmental Health and Injury					287,474								287,474
Occupational Safety and Health						262,883							262,883
Global Health							379,624						379,624
Public Health Research										31,000			31,000
Public Health Improvement & Leadership									161,592	82,846	19,668		264,106
Prev. Hlth./Hlth. Services Block Grant			98,932										98,932
Building & Facilities										158,291			158,291
Business Services Support												317,576	317,576
Terrorism								1,631,173					1,631,173
Pandemic Influenza - FY 2006 One-Time Funding		50,000		27,000									77,000
Pandemic Influenza Second Supplemental										200,000			200,000
Total, CDC	**0**	**1,745,156**	**1,056,957**	**245,905**	**287,474**	**262,883**	**379,624**	**1,631,173**	**161,592**	**472,137**	**19,668**	**317,576**	**6,580,145**
Agency for Toxic Substances & Disease Registry	74,905												74,905
Vaccines For Children		1,974,295											1,974,295
Total, CDC/ATSDR[2]	**74,905**	**3,719,451**	**1,056,957**	**245,905**	**287,474**	**262,883**	**379,624**	**1,631,173**	**161,592**	**472,137**	**19,668**	**317,576**	**8,629,345**

[1]Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director.

[2]Total for CDC/ATSDR does not include User Fees ($2,226).

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (2007)

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
FUNDING BY PROGRAM AND ORGANIZATION -- FY 2007[1]
(DOLLARS IN THOUSANDS)

	ATSDR	CCID[2]	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD[2]	OWCD	BSS	Total
Infectious Diseases		1,658,626											1,785,684
Health Promotion			958,687										958,687
Health Information and Service				218,966									218,966
Environmental Health and Injury					287,674								287,674
Occupational Safety and Health						252,999							252,999
Global Health							310,420						310,420
Public Health Research										31,000			31,000
Public Health Improvement & Leadership									161,703	7,851	19,682		189,236
Prev. Hlth./Hlth. Services Block Grant			99,000										99,000
Building & Facilities										133,638			133,638
Business Services Support												317,781	317,781
Terrorism								1,543,947					1,543,947
Total, CDC	**0**	**1,658,626**	**1,057,687**	**218,966**	**287,674**	**252,999**	**310,420**	**1,543,947**	**161,703**	**172,489**	**19,682**	**317,781**	**6,001,974**
Agency for Toxic Substances & Disease Registry	74,905												74,905
Vaccines For Children		2,905,330											2,905,330
Total, CDC/ATSDR[3]	**74,905**	**4,563,956**	**1,057,687**	**218,966**	**287,674**	**252,999**	**310,420**	**1,543,947**	**161,703**	**172,489**	**19,682**	**317,781**	**8,982,209**

[1] Funding in FY 2007 reflects the Continuing Resolution estimate.

[2] Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director.

[3] Total for CDC/ATSDR does not include User Fees ($2,226).

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (2008)

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
FUNDING BY PROGRAM AND ORGANIZATION – FY 2008
(DOLLARS IN THOUSANDS)

	ATSDR	CCID[1]	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD[1]	OWCD	BSS	Total
Infectious Diseases		1,794,368											1,794,368
Health Promotion			958,732										958,732
Health Information and Service				243,496									243,496
Environmental Health and Injury					287,674								287,674
Occupational Safety and Health						252,998							252,998
Global Health							379,719						379,719
Public Health Research										31,000			31,000
Public Health Improvement & Leadership									162,879	7,851	19,682		190,412
Prev. Hlth./Hlth. Services Block Grant													0
Building & Facilities										20,000			20,000
Business Services Support												319,877	319,877
Terrorism								1,504,375					1,504,375
Total, CDC	**0**	**1,794,368**	**958,732**	**243,496**	**287,674**	**252,998**	**379,719**	**1,504,375**	**162,879**	**58,851**	**19,682**	**319,877**	**5,982,651**
Agency for Toxic Substances & Disease Registry	75,004												75,004
Vaccines For Children		2,761,957											2,761,957
Total, CDC/ATSDR[2]	**75,004**	**4,556,325**	**958,732**	**243,496**	**287,674**	**252,998**	**379,719**	**1,504,375**	**162,879**	**58,851**	**19,682**	**319,877**	**8,819,612**

[1] Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director.

[2] Total for CDC/ATSDR does not include User Fees ($2,226).

MECHANISM TABLE – BUDGET ACTIVITY

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
MECHANISM TABLE - BY BUDGET ACTIVITY[1]
(DOLLARS IN THOUSANDS)

Budget Activity	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Infectious Diseases	**$1,695,156**	**$1,658,626**	**$1,794,368**	**$135,742**
Intramural Research and Program Assistance	$261,930	$277,174	$302,965	$25,791
Extramural Programs	$1,396,809	$1,343,487	$1,453,438	$109,951
PHS Evaluation Transfers	$36,417	$37,965	$37,965	$0
Health Promotion	**$958,025**	**$958,687**	**$958,732**	**$45**
Intramural Research and Program Assistance	$131,427	$130,643	$130,650	$7
Extramural Programs	$805,699	$806,256	$806,294	$38
PHS Evaluation Transfers	$20,899	$21,788	$21,788	$0
Health Information and Service	**$218,905**	**$218,966**	**$243,496**	**$24,530**
Intramural Research and Program Assistance	$152,192	$137,044	$152,621	$15,577
Extramural Programs	$64,796	$79,923	$88,876	$8,953
PHS Evaluation Transfers	$1,917	$1,999	$1,999	$0
Environmental Health and Injury Prevention	**$287,474**	**$287,674**	**$287,674**	**$0**
Intramural Research and Program Assistance	$104,986	$106,811	$106,811	$0
Extramural Programs	$176,222	$174,330	$174,330	$0
PHS Evaluation Transfers	$6,266	$6,533	$6,533	$0
Occupational Safety and Health	**$262,883**	**$252,999**	**$252,998**	**($1)**
Intramural Research and Program Assistance	$174,555	$170,521	$170,521	$0
Extramural Programs	$88,329	$82,478	$82,477	($1)
PHS Evaluation Transfers	$0	$0	$0	$0
Global Health	**$379,624**	**$310,420**	**$379,719**	**$69,299**
Intramural Research and Program Assistance	$90,780	$72,396	$90,136	$17,740
Extramural Programs	$282,061	$230,952	$282,511	$51,559
PHS Evaluation Transfers	$6,783	$7,072	$7,072	$0
Public Health Research	**$31,000**	**$31,000**	**$31,000**	**$0**
Intramural Research and Program Assistance	$2,976	$2,976	$2,976	$0
Extramural Programs	$28,024	$28,024	$28,024	$0
PHS Evaluation Transfers	$0	$0	$0	$0
Public Health Improvement & Leadership	**$264,106**	**$189,236**	**$190,412**	**$1,176**
Intramural Research and Program Assistance	$206,106	$149,621	$150,554	$933
Extramural Programs	$57,575	$39,172	$39,415	$243
PHS Evaluation Transfers	$425	$443	$443	$0
Prev. Health & Health Services Block Grant	**$98,932**	**$99,000**	**$0**	**($99,000)**
Intramural Research and Program Assistance	$1,187	$1,188	$0	($1,188)
Extramural Programs	$97,745	$97,812	$0	($97,812)
PHS Evaluation Transfers	$0	$0	$0	$0

FY 2008 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
MECHANISM TABLE - BY BUDGET ACTIVITY[1]
(DOLLARS IN THOUSANDS)

Budget Activity	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Building and Facilities	**$158,291**	**$133,638**	**$20,000**	**($113,638)**
Intramural Research and Program Assistance	$158,291	$133,638	$20,000	($113,638)
Extramural Programs	$0	$0	$0	$0
PHS Evaluation Transfers	$0	$0	$0	$0
Business Services Support	**$317,576**	**$317,781**	**$319,877**	**$2,096**
Intramural Research and Program Assistance	$302,967	$303,163	$305,163	$2,000
Extramural Programs	$14,608	$14,618	$14,714	$96
PHS Evaluation Transfers	$0	$0	$0	$0
Terrorism	**$1,631,173**	**$1,543,947**	**$1,504,375**	**($39,572)**
Intramural Research and Program Assistance	$357,989	$344,888	$335,984	($8,904)
Extramural Programs	$1,270,684	$1,196,559	$1,165,891	($30,668)
PHS Evaluation Transfers	$2,500	$2,500	$2,500	$0
FY 2006 Pandemic Influenza One-Time Funding (DoD)	**$77,000**	**$0**	**$0**	**$0**
Intramural Research and Program Assistance	$19,250	$0	$0	$0
Extramural Programs	$57,750	$0	$0	$0
PHS Evaluation Transfers	$0	$0	$0	$0
FY 2006 Pandemic Influenza Second Supplemental	**$200,000**	**$0**	**$0**	**$0**
Intramural Research and Program Assistance	$44,200	$0	$0	$0
Extramural Programs	$155,800	$0	$0	$0
PHS Evaluation Transfer	$0	$0	$0	$0
CDC Budget Authority Total	**$6,580,145**	**$6,001,974**	**$5,982,651**	**($19,323)**
Intramural Research and Program Assistance	$2,008,836	$1,830,063	$1,768,381	($61,682)
Extramural Programs	$4,496,102	$4,093,611	$4,135,970	$42,359
PHS Evaluation Transfers	$75,207	$78,300	$78,300	$0
Agency for Toxic Substances and Disease Registry	**$74,905**	**$74,905**	**$75,004**	**$99**
Intramural Research and Program Assistance	$58,426	$58,426	$58,503	$77
Extramural Programs	$16,479	$16,479	$16,501	$22
PHS Evaluation Transfers	$0	$0	$0	$0
Vaccines for Children	**$1,974,295**	**$2,905,330**	**$2,761,957**	**($143,373)**
Intramural Research and Program Assistance	$45,409	$66,823	$63,525	($3,298)
Extramural Programs	$1,928,886	$2,838,507	$2,698,432	($140,075)
PHS Evaluation Transfers	$0	$0	$0	$0
PHS Evaluation Transfers (non-add)	**$265,100**	**$265,100**	**$266,000**	**$900**
Intramural Research and Program Assistance	$145,540	$145,540	$146,034	$494
Extramural Programs	$119,560	$119,560	$119,966	$406
PHS Evaluation Transfers	$0	$0	$0	$0
CDC/ATSDR Program Level Total [2]	**$8,629,345**	**$8,982,209**	**$8,819,612**	**($162,597)**
Intramural Research and Program Assistance	$2,112,671	$1,955,312	$1,890,409	($64,903)
Extramural Programs	$6,441,467	$6,948,597	$6,850,903	($97,694)
PHS Evaluation Transfers	$75,207	$78,300	$78,300	$0

[1] The intramural/extramural split for CDC's budget activities is an estimate and will be updated in the coming months.

[2] Funding levels do not include total amount for user fees ($2,226).

PRESIDENT'S MANAGEMENT AGENDA

OVERVIEW

Included in this section are CDC's key program management activities to address key aspects of the President's Management Agenda (PMA). The activities below briefly describe CDC's progress in these areas and outline some important initiatives designed to further improve the agency's program management.

CDC has been actively pursuing goals and improvements related to the PMA for several years. For example, CDC decreased its proportion of administrative positions by six percent from 1997 to 2001. CDC has historically focused on keeping the agency market-based and efficient by having approximately 6,000 service contractor staff engaged to conduct commercially-oriented responsibilities. In addition, CDC established its Fiscal Management Excellence Initiative in 2000, which has further enhanced improvements in fiscal performance. CDC is organized to effectively address and lead PMA issues. For example, CDC has established a Management Council to help concentrate management attention on the PMA.

PROGRESS ON PRESIDENT'S MANAGEMENT AGENDA

CDC made major achievements in addressing the President's Management Agenda (PMA) objectives. CDC has consolidated or restructured nearly 40 major human capital or business services improvements and more than doubled its supervisory ratio, thereby making the agency more efficient and effective. CDC has maintained its reasoned strategic planning approach in Competitive Sourcing for FY 2002 - FY 2005. Another major, successful effort is implementing HHS' Unified Financial Management System (UFMS) which integrates the Department's financial management structure and provides HHS leaders with a more timely and coordinated view of critical financial management information. Furthermore, CDC has made extraordinary progress in Expanded Electronic Government initiatives, such as consolidating IT infrastructure services, having a leadership role in the establishment of a multi-department architecture for the President's Biosurveillance Initiative, and being actively engaged in HHS' modernization efforts. CDC's efforts to integrate budget and performance have taken on increased significance as the agency continues work to implement a new strategy and organization under the Futures Initiative. Recently, the agency announced modernizations to enhance health impact, support the capacity to respond to public health emergencies, and to directly engage CDC's customers, the American public.

STRATEGIC MANAGEMENT OF HUMAN CAPITAL INITIATIVE

CDC's significant growth in its workforce over the past years is attributable to an ever-expanding public health mission. From FY 1996 to present, the number of employees has grown from 6,406 to 9,130 - an increase of nearly 43 percent. This trend clearly reflects the agency's expanded disease prevention and control responsibilities. CDC's workforce is comprised of individuals working in over 170 job series with an emphasis on scientific and medical occupations. Approximately two-thirds of CDC employees work in the Atlanta headquarters area. However, the agency has a major presence (defined here as more than 50 employees) in such diverse geographical areas as Cincinnati, OH; Morgantown, WV; Hyattsville, MD; Pittsburgh, PA; Washington, D.C.; Spokane, WA; Durham, NC; and Fort Collins, CO. CDC's overseas presence will be up to 250 employees this year.

WORKFORCE RESTRUCTURING

CDC continues to promote and enhance its Strategic Management of Human Capital initiatives in support of the PMA. These initiatives include reducing layering, eliminating administrative positions through consolidation, further improving our supervisory ratio, and supporting the transition of our workforce toward providing more frontline public health functions.

CDC had already consolidated most of its program support offices to eliminate duplication prior to the PMA. Centralized offices included equal employment opportunity, procurement, human resources, facilities operations, security and emergency preparedness, and others. This consolidation resulted in substantial savings and efficiencies. CDC has undertaken a wide range of additional administrative consolidations and business improvements.

Administrative Consolidations

- CDC more than doubled its supervisory ratio from 1:5.5 in 2002 to over 1:12.6 in 2006. This documents the overall success in flattening organizations, reducing management layers, and consolidating and/or restructuring administrative functions.
- CDC consolidated 13 information technology (IT) infrastructure functions, services, staff and fiscal resources into the new Information Technology Services Office (ITSO). This consolidation reduced operating costs by 30 percent and staff by 29 percent.

- A complex and innovative approach to administrative/management consolidation was used to functionally merge the Office of the Director (OD) in both ATSDR and NCEH into one unit. FTE savings of 18 percent (35 FTEs) have already been realized.
- CDC is effectively completing its Business Services Consolidation Plan. This is an overarching strategy, approved by HHS in July 2003, to reduce administrative positions, centralize reporting and supervisory relationships, and establish agency-wide shared services.
- CDC consolidated the agency's medical and professional inquiry hotlines. CDC awarded a performance-based contract for consolidated public and professional health information services reducing over 40 hotlines to one. This will expand services (24x365, multilingual, hearing impaired) and save about $35 million over seven years.
- CDC consolidated graphics services across the agency in FY 2005. This action resulted in fiscal and staff savings, including savings expected from more efficient use of equipment, that can be redirected to mission direct activities.
- CDC completed the evaluation and detailed planning for the consolidation of professional training services. Implementation of consolidated professional training services across the agency is expected to be complete in FY 2006 - 2007. CDC has been working with HHS to implement the HHS Learning Management System.
- CDC completed the evaluation and detailed planning for consolidation of travel services in 2005 with associated fiscal and staff savings for redirection to mission direct activities. In FY 2006, CDC fully implemented e-travel services throughout the agency.
- CDC, with HHS' guidance, completed the restructuring of its human resources office to the HHS Atlanta Human Resources Center (AHRC). This human resources office restructuring eliminated 76 FTEs, reflecting a 30 percent staff reduction. Despite this reduction, the time from AHRC's receipt of a hiring request to the day the job offer is made was reduced by 47 percent between 2003 and 2004.
- CDC consolidated administrative functions in approximately 30 CDC/OD offices, reducing staffing from a baseline of 83 FTEs to 63, or a savings of 24 percent. This action resulted in savings that can be redirected to mission direct activities.
- As a result of these human capital and other CDC business services improvements, the agency has reduced its number of mission support (i.e., administrative) staff by approximately 900 as of the end of 2005. This reduction of mission support staff will allow the redirection of administrative staff positions to front line public health efforts.

Business Process Improvements

CDC successfully implemented a state-of-the-art financial system, UFMS in April 2005. UFMS is part of a multi-year effort initiated by Former Secretary Thompson. CDC went "live" with UFMS' General Ledger and Accounting for Pay System in October 2004. The grants interface (Grants Solution) was also implemented in the first quarter of FY 2005.

CDC is improving procurement and grants operations. Operational improvement opportunities have been identified that will result in increased employee productivity through workforce alignment, process redesign, and operational performance management. This effort has already resulted in new contract cycle time being reduced by 54 percent between FY 2003 and FY 2006.

CDC evaluated vaccine purchase processes and will streamline CDC's purchase of over half of the nation's childhood vaccines through its Vaccine Management Improvement Project.

The Office of Personnel Management approved CDC/ATSDR's plan to offer Voluntary Separation Incentive Payments (VSIPs), or buyouts, to staff who worked in mission support functions in FY 2005. Under the VSIP authority, 336 mission support staff separated during FY 2005. CDC's plan was to use the VSIPs to help implement major reorganizations and business services consolidations which resulted in significant business efficiencies and redeployment of positions to front line public heath efforts. In FY 2006, 15 staff separated under VSIP.

CDC has effectively used Voluntary Early Retirement Authority (VERA) to reduce mission support staff and restructure efficiencies accordingly. In FY 2003, 73 staff accepted VERA. In FY 2004 and FY 2005, 39 and 93 staff, respectively, retired early under VERA. In FY 2006, 3 staff accepted VERA.

Delayering Actions

CDC has completed delayering the agency to no more than four management layers. In total, CDC abolished over 200 "Sections" in response to this initiative. This "Section" delayering has contributed to a 33 percent decrease in the

official number of organizational units at CDC since 2001. This agency-wide approach resulted in compressing the distance between citizens and decision-makers.

FY 2007 ACTIVITIES

- CDC will continue to flatten the agency by further improving its supervisory ratio.
- CDC/ATSDR will continue efforts to redirect more mission support staff to mission direct positions.
- CDC will strategically retrain and redeploy employees impacted by initiatives such as competitive sourcing, consolidations, and reduction of mission support positions.

COMPETITIVE SOURCING INITIATIVE

COMPETITIVE SOURCING PLAN

CDC developed a long range Competitive Sourcing plan to guide the program and the resulting competitions each year. This plan reflects consideration of where and how competitive sourcing can best further CDC's mission, human capital plans and maximize our savings potential. CDC has continually met the plans' goals and maintained "green" PMA scorecard performance ratings.

COMPETITIONS

In FY 2003, CDC completed five studies of its Facilitates Planning and Management Office. CDC prevailed in all five studies, indicating that through rigorous and complex analysis of work, CDC was performing at a cost to the taxpayer less than that of comparable service providers.

In FY 2004, CDC conducted six A-76 competitions involving a range of CDC staff. The specific competitions included: (1) Animal Care, (2) Laboratory, Glassware and Associated Laundry services, (3) Office Automation, (4) Printing (5) Materials Management and (6) Library Services. Again, except for the small printing streamlined study, five of the competitions resulted in in-house decisions. The Library Services performance decision was not announced until FY 2005. This record indicates that through rigorous and complex analysis of commercial work, CDC performs at a cost to the taxpayer less than that of other service providers.

In FY 2005, three new standard competitions were announced for Computer Clerk Support, Statistical Support, and Writer and Editor Services. All three competitions resulted in in-house decisions. These FY 2005 competitions included approximately 150 FTEs. In addition to the standard competitions, the CDC Information Technology Services Office was approved by OMB as a "restructuring" alternative to A-76 competitions. The organization will achieve comparable savings over the next five years.

In FY 2006, CDC maximized the opportunity to leverage the new "CDC Now" organizational structure and other reorganizations involving business service functions. This opportunity allows CDC to improve efficiency and effectiveness in the delivery of business services within new coordinating centers/coordinating offices. Proposals for High Performing Organizations (HPOs), an alternative to A-76 competition, have been developed and submitted to OMB for the Financial Management Budget Execution Services function and the Public Health Integrated Business Services initiative. These HPO proposals involve over 1,500 commercial FTEs and represent a significant opportunity for CDC to reduce cost in mission support functions and modernize business systems across the agency.

COMPETITIVE SOURCING SAVINGS

CDC savings that accrue from competitive sourcing are reinvested in mission-direct, public health activities. For example, reductions in FTEs associated with mission support functions will be redirected to activities such as epidemiology, laboratory science, medical officials, and pandemic preparedness teams. Information technology savings are used to fund projects that support Health IT, science and other core mission activities such as linking public health and electronic medical records. Similarly, as CDC's mission continually expands with new and re- emerging diseases and health risks, savings are effectively invested in meeting urgent challenges such as avian influenza, tsunami response teams, and hurricane disaster relief efforts. Moreover, new requirements are resulting from opening the new CDC laboratory facilities and Global Communications Center as part of our facilities modernization program. This will help make our health protection tools and information accessible to the global community. CDC is participating in independent audits sponsored by HHS to validate our performance and savings.

IMPROVED FINANCIAL PERFORMANCE INITIATIVE

UNITED FINANCIAL MANAGEMENT SYSTEM (UFMS)

The Unified Financial Management System (UFMS) is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has been in production for the CDC and FDA for over a year, with new functionality releases of Grants and IVR in October 2005 and eTravel in April 2006. The PSC implementation was moved to production on October 16, 2006.

The PSC has the responsibility for ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications, and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. In accordance with Federal and HHS policy, the UFMS application is under an approval to operate through February 16, 2007 by the designated Certifying Authority and Designated Approving Authority (DAA). The UFMS application will be approved for operation for 1 year after this date. After October 2007, when all OPDIVs will be operational on UFMS, then a 3-year certification will be completed. This approval to operate assures that the necessary security controls have been properly reviewed and tested as required by the Federal Information Security Management Act (FISMA). CDC requests $6,205,562 to support these efforts in FY 2008.

With the implementation of a modern accounting system, HHS has efforts underway to consolidate and implement automated administrative systems that share information electronically with UFMS. These systems will improve the business process flow within the Department, improve Funds Control and provide a state of the art integrated Financial Management System encompassing Finance, Budget, Acquisition, Travel and Property. As the UFMS project is nearing completion, the integration of administrative systems is the next step in making these processes more efficient and effective. CDC requests $511,580 to support these efforts in FY 2008.

With the implementation of UFMS, CDC continues to pursue an aggressive strategy to upgrade fiscal management activities by bridging UFMS to the analytical and reporting tools necessary to respond to complex financial management requirements. These analytical and reporting tools position CDC to respond to current, future and contingency financial management requirements. To accomplish this strategy, CDC planned a multi-phased approach to UFMS. In October 2004, CDC implemented core UFMS Phase I. Core UFMS Phase I Implementation entailed deploying the UFMS General Ledger and Accounting for Pay Systems. In addition, CDC deployed the UFMS Interim Grants Solution in December 2004. This covered more than 50 percent of the dollar and transaction volume of the agency. In April 2005, CDC completed the full UFMS financial and accounting implementation of Phase I which is the cornerstone for future UFMS development and follow-up activities.

Phase II of UFMS started in FY 2005 with continuation into FY 2006 and FY 2007. Phase II will entail multiple tasks to include exploring the possibility of moving CDC to a fully project centric environment, modification of CDC feeder systems to support this environment, and development of a CDC data warehouse that will merge programmatic and financial information for meaningful management reporting. To this end, CDC commissioned and completed a business case to identify timelines, accurate cost estimates, preferred functional and technical solutions and a strategic plan to accomplish these efforts. The business case is currently under consideration. Other activities that will be included in Phase II include piloting the MarkView Invoice Imaging system for UFMS and integrating a number of other departmental business systems with the UFMS core financials. These systems include E Gov Travel, Sunflower property management, IMPAC II for grants processing, iProcure/Prism for acquisitions and Learning Management System for Training. In addition to Phase II development, CDC will also need to plan for Phase I support. This will include continued funding to the HHS UFMS effort, post implementation support, and maintenance and support of non-Oracle systems.

HHS Consolidated Acquisition System

The HHS Consolidated Acquisition System (HCAS) initiative is a Department-wide contract management system that will integrate with the UFMS. The applications within the HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a federalized contract management system that helps streamline the procurement process. The implementation of PRISM includes the functionality of contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post award tracking, contract closeout and reporting. Major functions, once integrated with the UFMS, include transfer of iProcurement requisition

for commitment accounting and funds verification to PRISM and transmission of the award obligation from PRISM to Oracle Financials.

Benefits:

The following benefits will be realized by the Department and the individual OPDIVs/STAFFDIVs once the HCAS system is fully implemented:

- Commitment Accounting
- Integration to other HHS Administrative Systems
- Decreased Operational Costs
- Increased Efficiency and Productivity
- Improved Decision Making – Unified systems
  - Data Integrity
  - Reporting
  - Performance Measurement
  - Financial Accountability
- Standardization
  - Business Processes
  - Information Technology
- Consistent Customer Service Levels
- Refocus personnel efforts on value-added tasks
- Knowledge Sharing
- System Enabled Work
  - HHS Acquisition Personnel – contracting
  - Customers in requirement preparation – requisitioning
- Meets Organizational Drivers and Goals (President's Management Agenda, One-HHS, OMB Line of Business)

The HCAS team is working closely with the UFMS PMO and HHS PMO to ensure a smooth roll out of both PRISM and iProcurement. An integrated team, including personnel from UFMS, Acquisition and Assets has been formed to ensure maximum utilization of in-house expertise. CDC requests $2,401,260 to support these efforts in FY 2008.

FINANCIAL MANAGEMENT IMPROVEMENT

In FY 2003, CDC successfully began issuing quarterly financial statements and accelerating the closing of accounting records at the end of the fiscal year. The use of automated tools has expedited the financial data consolidation process and streamlined financial statement preparation. CDC continues to prepare timely quarterly statements and implement reviews, checks, reconciliations, and functions analysis to ensure the accuracy and completeness of financial statements. CDC is also proceeding with its Financial Management Excellence Initiative to further improve financial operations by following guidelines set by PricewaterhouseCoopers and the U.S. General Accounting Office in their respective November, 2000 reports.

ACCOUNTABILITY

CDC participated in the HHS "top down" audit approach in FY 2003 through FY 2006 for which HHS received clean opinions. CDC will participate in the HHS "top-down" audit for FY 2007. Additionally, CDC received five consecutive clean audit opinions from FY 1998 through FY 2002 as evidenced in the independent auditors' report in the CDC/ATSDR Chief Financial Officer's annual reports for the applicable years. CDC also performs management control reviews and risk assessments pursuant to the Federal Managers' Financial Integrity Act and OMB Circular A-123. CDC reports results to HHS in an annual report.

As part of the Corrective Action Plan, CDC anticipates UFMS-generated financial statements by the end of the first quarter in FY08. CDC is working with UFMS Global and contractors to devise an automated procedure for financial statement preparation.

EXPANDED E-GOVERNMENT INITIATIVE

CDC's request includes funding to support the PMA's Expanding E-Government and Departmental enterprise information technology initiatives. The **CDC** will contribute **$5,710,805** of its FY 2008 budget to support Department enterprise information technology initiatives as well as the President's Management Agenda (PMA) Expanding E-Government initiatives. Operating Division contributions are combined to create an Enterprise Information Technology (EIT) Fund that finances both the specific HHS information technology initiatives identified through the HHS Information Technology Capital Planning and Investment Control process and the PMA initiatives. These HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability. The HHS Department initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, **$1,534,959** is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2008. The balance of the EIT fund will be used to support HHS-wide initiatives. The amount supporting the PMA E-Government initiatives as follows:

PMA e-Gov Initiative	FY 2007 Allocation	FY 2008 Allocation
Business Gateway	$109,172	$71,923
E-Authentication	$0	$24,456
E-Rulemaking	$0	$0
E-Travel	$0	$66,993
Grants.Gov	$251,213	$258,750
Integrated Acquisition	$220,224	$226,946
Geospatial LoB	$59,357	$61,138
Federal Health Architecture LoB	$757,661	$729,912
Human Resources LoB	$17,771	$17,771
Grants Management LoB	$13,254	$26,170
Financial Management LoB	$13,778	$23,620
Budget Formulation & Execution LoB	$12,401	$14,054
IT Infrastructure LoB	$13,227	$13,227
TOTAL	**$1,468,058**	**$1,534,959**

Prospective benefits from these initiatives are:

Business Gateway: Provides cross-agency access to government information including: forms; compliance assistance resources; and, tools, in a single access point. The site offers businesses various capabilities including: "issues based" search and organized agency links to answer business questions; links to help resources regarding which regulations businesses need to comply with and how to comply; online single access to government forms; and, streamlined submission processes that reduce the regulatory paperwork burdens. HHS' participation in this initiative provides HHS with an effective communication means to provide its regulations, policies, and forms applicable to the business community in a business-facing, single access point.

E-Authentication: Provides standards-based authentication architecture to support Federal E-Government applications and initiatives. It provides a uniform process for establishing electronic identity and eliminates the need for redundant solutions for the verification of identity and electronic signatures. E-Authentication's federated architecture also enables citizens and businesses to use credentials issued by commercial entities, such as financial

institutions, to conduct transactions with the government, eliminating the need for HHS to issue credentials for its systems.

E-Rulemaking: Provides citizens and organizations a single point of access to Federal rulemaking information. HHS posts all rulemaking notices on Regulations.gov. HHS and E-Rulemaking are in the requirements and planning process for migrating HHS docket-management process to the E-Rulemaking system.

E-Travel: The E-Travel Program provides a standard set of travel management services government-wide. These services leverage administrative, financial and information technology best practices. By the end of FY 2006, all but one HHS OPDIV has consolidated services to GovTrip and legacy systems retired. By May 2008, all HHS travel will be conducted through this single system and the last remaining legacy functions will be retired.

Grants.gov: Allows HHS to publish grant funding opportunities and application packages online while allowing the grant community (state, local and tribal governments, education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms, processes and systems. In FY 2006, HHS received over 56,000 electronic applications from the grants community via Grants.gov.

Integrated Acquisition Environment: Eliminated the need for agencies to build and maintain their own agency-specific databases, and enables all agencies to record vendor and contract information and to post procurement opportunities. Allows HHS vendor performance data to be shared across the Federal government.

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business-Geospatial One-Stop: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. An HHS agency, Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence and has applied to be a GMLOB consortia lead. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Lines of Business–IT Infrastructure: A recent effort, this initiative provides the potential to leverage spending on commodity IT infrastructure to gain savings; to promote and use common, interoperable architectures that enable data sharing and data standardization; secure data interchanges; and, to grow a Federal workforce with interchangeable skills and tool sets.

CDC Engagement in Government-Wide E-Gov Projects

CDC is actively engaged in eight of the federal E-Gov initiatives, namely Federal Health Architecture, CHI, e-Vitals, e-Grants, e-Travel, Geospatial Information One Stop, SAFECOM, and GovBenefits, with an initial 16 CDC programs represented covering $4.4 billion. CDC has actively advanced e-commerce using FedBizOpps to post all contract opportunities electronically. CDC has migrated to HHS' enterprise-wide grants management system for research grants using NIH's eRA (IMPAC II) system and has migrated other grants to the same system in FY 2006. CDC is co-chairing the FHA surveillance working group and has actively participated in the interoperability working group and the data architecture working group. CDC met the October 2003 goal for the Government Paperwork Elimination Act to make all information collections and disseminations available electronically.

CDC E-GOV Initiatives

ENTERPRISE ARCHITECTURE

CDC continues to advance in its Enterprise Architecture (EA) development. Recent accomplishments include ongoing work of CDC's Enterprise Architecture Board (EAB) made up of Agency-wide representatives; closer linkage with the Capital Planning and Investment Control (CPIC) process; and actively contributing to HHS' EA Model Working Group and EA Review Board. The resulting effort has raised CDC to Level 3 of OMB Enterprise Architecture Assessment Framework (EAAF). In addition to modeling CDC's Health Alerts Domain, the EA team has expanded its guidance into other key public health related functions, such as laboratory informatics.

SECURITY

CDC actively participates in the HHS Secure One program by maturing its strong information security program which is comprised of a Certification and Accreditation (C&A) and security assessment program, information security awareness training, policy development, test and evaluation, and security operations activities. CDC has focused on increasing effectiveness and efficiencies this year by identifying common controls that can be applied across the enterprise and beginning to implement master system security plans that take advantage of those security controls to meet NIST requirements. CDC again completed Business Continuity Planning and testing for all of the 24 Federal Information Security Management Act (FISMA) critical systems and Business Continuity activities continue on an ongoing basis. CDC has further refined its Plan of Action and Milestone program to manage, mitigate, and validate remediation of system and enterprise weaknesses.

HHS MODERNIZATION

Government-Wide E-Gov Projects

CDC is actively engaged in eight of the federal E-Gov initiatives, namely Federal Health Architecture, CHI, e-Vitals, e-Grants, e-Travel, Geospatial Information One Stop, SAFECOM, and GovBenefits, with an initial 16 CDC programs represented covering $4.4 billion. CDC has actively advanced e-commerce using FedBizOpps to post all contract opportunities electronically. CDC has migrated to HHS' enterprise-wide grants management system for research grants using NIH's eRA (IMPAC II) system and has migrated other grants to the same system in FY 2006. CDC is co-chairing the FHA surveillance working group and has actively participated in the interoperability working group and the data architecture working group. CDC met the October 2003 goal for the Government Paperwork Elimination Act to make all information collections and disseminations available electronically.

IT Infrastructure Consolidation

CDC consolidated the agency's IT infrastructure functions, services, staff, and fiscal resources in accordance with OMB and HHS instructions. CDC has reduced costs by 38 percent and reduced staff by 29 percent in line with the overall agency reduction in mission support staffing. The 13 functions defined as IT infrastructure are: desktop computing support, directory services, e-mail, helpdesk support, infrastructure software, IT security, networking, data center services, office automation, remote access, server management, videoconferencing, and telecommunications.

Citizen-Centered Service

CDC launched its newly redesigned web site. Key improvements include making the site more citizen-centered including improvements in use, navigation, searching, interactivity, personalization, and enriching and expanding content in a consumer-oriented presentation. CDC has one of the most frequently visited Web sites in the government as the authoritative trusted source of public health information for health care providers, public health officials, the media, and the public. CDC's web site attracts 13 million different visitors per month on average. After Hurricane Katrina, over 22 million visited the site in September 2005 and 20 million visited due to influenza in November 2005.

CDC consolidated all of its more than 40 health information hotlines and clearinghouses into one consolidated consumer response service at 1-800-CDC-INFO. The service went live in March 2005 with the initial conversion of HIV/AIDS, STDs, and immunization hotlines. Additional health topic areas have been successfully converted such as Emergency Preparedness, Cancer, Physical Activity and Nutrition, Diabetes and School Health, Birth Defects, Smoking and Health, Injury, TB, and Environmental Health. Currently, there are 3,794 prepared responses available in the data base to support programs that have already transitioned. The new service handles public inquiries 24 hours per day, every day, in bilingual and services hearing impaired callers. The contact center handled greater than 550,000 calls and 11,000 emails during the first year of operation and is continually growing as new health topics are added to the contact service.

FEDERAL REAL PROPERTY ASSET MANAGEMENT INITIATIVE

In compliance with the Federal Real Property Asset Management Initiative, CDC has established a Senior Real Property Officer and a Federal Real Property Council to ensure that the CDC is meeting the guidelines that have been established by the initiative:

- *Senior Real Property Officer*- This Officer was designated to serve as the senior manager tasked with developing and implementing an agency asset management plan. Specifically, the Officer will: identify and categorize any real property owned, leased, or otherwise managed by the agency; prioritize actions to be taken to improve the operational and financial management of inventory; make life-cycle cost estimations associated with the prioritized actions; identify legislative authorities that are required to address the priorities; identify and pursue goals and targets with appropriate time frames and deadlines; provide advice on adequate budget amounts for activities; and focus on those activities and efforts allowed under current law.
- *Federal Real Property Council*- This Council will serve as a working group to facilitate the success of the agency's asset management plans. The Council will be composed of all agency Senior Real Property Officers, the Controller of the Office of Management and Budget, and the Administrator of General Services. The Deputy Director for Management of the Office of Management and Budget will be a member and serve as the chair of the Council. The Council will establish appropriate performance measurements for evaluating the costs and benefits involved with acquiring, repairing, maintaining, operating, managing, and disposing of Federal real properties at particular agencies. The Council will also serve as a clearinghouse for best practices in evaluating actual progress in the implementation of real property enhancements.

BUDGET AND PERFORMANCE INTEGRATION INITIATIVE

CDC's efforts to integrate budget and performance have increased as the agency implements a new strategy and organization. The agency continues to modernize to enhance health impact, support the capacity to respond to public health emergencies, and directly engage CDC's customers, the American public.

Across CDC, integration efforts are reflected in the development of the agency's Performance Budget. This document aggregates performance information, required under the Government Performance and Results Act (GPRA), with budget information. The Performance Budget reflects:

- an emphasis on outcome-oriented measures that demonstrate the focus of CDC's programs.
- efficiency measures for all programs, per OMB instruction via the Program Assessment Rating Tool (PART) review.
- full costs calculated at the goal and performance measure level.
- coordination across CDC throughout the development of the FY 2008 Performance Budget and other integration activities.

SENIOR AGENCY MANAGER MEETINGS

CDC has implemented a Senior Agency Management retreat cycle to review its goals and objectives and the financial and performance information needed to accomplish them. The Executive Leadership Board (ELB) met in early January. The Center Leadership Council (CLC) met in late January and CDC Division Directors met in early February. Managers discussed annual goal plans, how effective CDC was in meeting those goals, how CDC's budget is aligned with goals, and what measures should be implemented in future years to improve the effectiveness of the agency in accomplishing its goals.

In addition, CDC has aligned agency PART measures with the CDC goal areas. Each ELB member with responsibility for a goal area will report on performance to other Board members.

Senior Agency managers from CDC's Financial Management Office (FMO), Office of Strategy and Innovation (OSI), and Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER) collaborated on the FY 2006 spend-plan process. The spend plan process was formulated to fund programs based on performance rather than allocation and is intended to map program success and methods used to budget and track resources contributing to health impacts. COTPER and OSI reviews and evaluates projects and provides recommendations on funding. Projects recommended for funding were submitted to FMO for a detailed review of the project budget, and finally, submitted to the Executive Leadership Board and HHS for final approval.

Additionally, senior managers from CDC's OSI, FMO, COPTER, Procurement and Grants Office (PGO), and the Management Information Systems Office (MISO) collaborated to develop FY 2006 joint planning activities for budget, goals, and extramural awards. This collaborative effort created a single planning process supported by Integrated Resources Information System (IRIS), budget and performance integration, and CDC's newly created health impact web-based system that will link resources to performance. CDC's health impact system is a tool which will allow staff to track projects, performance, budget, and health impact through a uniform electronic system across the agency.

CDC leadership held meetings to discuss the best strategies to fully implement the HHS Performance Management Appraisal Program. Part of the meetings were dedicated to finalizing a timeline for CDC policy development and analyzing historical funding data related to the new percentages of awards to forecast for budget impact in FY 2007.

Monthly and ad hoc financial management meetings occur at all levels of the organization with and between Coordinating Center Directors, Chief Management Officials, Division Directors and Branch Chief to define and establish clear objectives for both program and budget. Regular meetings are scheduled reinforcing or modifying goals as program and financial situations change.

PART

In 2002 through 2006, 22 CDC programs participated in a PART review by OMB: 317 Immunization Program, Breast and Cervical Cancer, Diabetes, Domestic HIV/AIDS Prevention, HAN, ATSDR, State and Local Preparedness, B&F, Epidemic Services and Response, Occupational Safety and Health, Infectious Diseases, STD/TB, Environmental Health, Global AIDS, in conjunction with the President's Emergency Plan for AIDS Relief, Global Immunization, Health Statistics and the Strategic National Stockpile, Chronic Disease Prevention and Health Promotion, Birth Defects and Developmental Disabilities, Injury Prevention and Control, BioSurveillance and Upgrading CDC Capacity. These programs have developed performance measures which are reported on in each submission of the performance budget. Many of the performance measures are outcome-oriented and support the direction of CDC's goals process. Many programs reviewed by PART have made improvements in strategy, program management and results based on OMB's recommendations. For example:

- CDC has initiated a business improvement project to revamp the entire vaccine distribution process which will strengthen the efficiency and accountability of vaccine management systems. Once fully implemented, the new systems will automate and integrate vaccine ordering and management by centralizing distribution of all public purchased vaccines.
- Breast and Cervical Cancer performance targets were increased in accordance with data submitted by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Federal Advisory Committee. This review was solicited as an independent verification of the effectiveness of the program in general, and a report of the first 12 years of the Breast and Cervical Cancer program was prepared and endorsed.
- CDC's Diabetes program completed a management analysis to determine how resources (i.e. human capital, time and funds) are being used to achieve National Program Objectives (NPO). The analysis successfully captured the internal and external influence, interaction and impact of resources.
- CDC's Domestic HIV/AIDS Prevention program developed a template for project officers' use to analyze progress reports from state health departments, Community-Based Organizations and providers. CDC is phasing-in the implementation of the Program Evaluation and Monitoring System (PEMS) which will allow CDC to augment qualitative data from grantee annual progress reports with quantitative data to show client and program effectiveness.
- CDC's Environmental Health program and ATSDR initiated an intramural review program to evaluate all of its activities and projects with the goal of identifying shortcomings and making recommendations for improvement. This program is conducted by the Peer Review Subcommittee of their Board of Scientific Counselors, an independent organization whose charter is to provide guidance to the program. The subcommittee will evaluate the entire Environmental Health program within the next five years.
- CDC has entered into a contract with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research program portfolio. In FY 2005, the NA Framework Committee established comprehensive evaluation criteria. To conduct the first phase of review, a NA evaluation panel

was assembled and employed the criteria to review mining and hearing loss prevention. NA panels are in the process of reviewing the mining and hearing loss programs and will provide a formal report with ratings in September 2006.

- ATSDR implemented a new long-term outcome measure for documenting the effectiveness of its interventions at sites that pose the most urgent public health hazards. ATSDR now evaluates its interventions at each site to determine their impact on public health. As a result, this new measure has focused the agency's leadership, its Cooperative Agreement Partners, and EPA on achieving public health outcomes.
- Critical tasks and performance measures were developed for the Public Health Emergency Preparedness Cooperative Agreement Program and were incorporated into the grant guidance for FY 2005.
- CDC's Occupational Safety and Health program initiated a contract with the National Academy of Sciences to conduct a comprehensive evaluation of the impact and relevance of occupational safety and health research.
- CDC's Infectious Diseases program has a website to post performance data on the grantee profile pages, including funding, activities funded, links to the grantees home page, grantee contact information and Congressional summaries (available for a limited number of grantees).
- CDC's TB program began to award state health department cooperative agreements for a new project cycle utilizing a new funding formula based on the burden of the disease.

Efficiency Measures

All CDC PART programs have at least one OMB-approved efficiency measure. These efficiency measures, along with their targets and actual performance, can be found in the Detail of Performance Analysis sections of this document.

FULL COST

CDC continues to report the full costs calculated at the goal and performance measure level in the Performance Budget. The full cost table has been changed to include the allocation of costs to the Vaccines for Children Program.

FAITH-BASED AND COMMUNITY INITIATIVE

CDC/CCHIS/NCHM's Division of Partnerships and Strategic Alliances Faith Based and Community Organization (FBCO) Team was established to facilitate the development of partnerships between public health and FBCOs in order to provide more effective health and human services.

Prepare for an Influenza Pandemic: Deploy a national communications strategy to provide accurate, timely, consistent, and comprehensive information about preparing for and responding to influenza and pandemic influenza to the public, the news media, health care providers, and other partners and stakeholders.

- Collaboration between FBCOs and CDC's Emergency Communications System. CDC led a series of focus groups about how best to communicate with FBCOs during emergencies. Invited participants included: the Church of Jesus Christ of Latter-Day Saints, the Salvation Army, the National Council of Churches' Church World Service, the Hindu nonprofit charity BAPS Care International, the United Way of America, the United Methodist Committee on Relief, the African Methodist Episcopal (AME) Church, CAUSE-NY/Jewish Community Relations Council of NY; the Emory Interfaith Health Program; the National Voluntary Organizations Active in Disaster (National VOAD); the Regional Council of Churches of Atlanta, Inc. and Southern Baptist Disaster Relief.

Enhance Emergency Response: Prepare faith-based and community organizations to prevent and address the health effects of a disaster. CDC has increased the nation's preparedness for a potential influenza pandemic and other health emergencies by:

- Serving as the lead author for the HHS Faith-based and Community Organization Pandemic Influenza Preparedness Checklist released by Secretary Leavitt on January 10, 2006. This checklist is a resource to provide various FBCOs with broad guidance on how to begin planning for pandemic influenza. The checklist has widespread geographic distribution and has been used by many diverse organizations. More than 61,000 FBCOs refer to or link to the checklist.
- Serving as the lead agency for the October 5-6, 2006 Roundtable discussions with FBCOs about pandemic influenza preparedness. At the request of the White House Homeland Security Council, CDC served as lead organizers working with the HHS Center for Faith Based and Community Initiatives and other federal

agencies to host roundtable discussions with faith-based, community-based, volunteer, and non-profit organizations about ways to reduce a severe flu pandemic.

- Participants included individuals from these and many other organizations: the African Methodist Episcopal Church (AME), the American Red Cross, Asbury Theological Seminary, the Church of Jesus Christ of Latter-Day Saints, the Jewish Community Relations Council, the Muslim Women's Institute for Research and Development, the National Council of the Churches of Christ in the USA, National 4-H Clubs, the Southern Baptist Convention, United Jewish Communities, the United Way of America, the Urban Institute and World Vision International.
- Developing a Partnership with the National Voluntary Organizations Active in Disaster (National VOAD). CDC established and oversees monthly conference calls with the National VOAD, an umbrella organization of over 40 nonprofit and faith-based agencies that regularly participate in disaster response. The American Red Cross and the National VOAD are the only nongovernmental organizations that are signatories to the National Response Plan. The National Response Plan does not name charities active in disaster relief other than the American Red Cross, but instead incorporates them into the National VOAD.
- Organizing a Pandemic Planning Webinar with National VOAD. On December 8, 2006, CDC delivered a pandemic planning Webinar with the National VOAD member organizations and others.
- Organizing a Pandemic Planning Webinar for National Jewish Organizations. On December 5, 2006, CDC delivered a pandemic planning Webinar for National Jewish Organizations. Over 130 Jewish Federations from across North America participated.
- Developing a Partnership with the Islamic Medical Association of North America (IMANA). CDC is collaborating on pandemic influenza preparedness planning with IMANA, a Muslim nonprofit public charity active in health initiatives and other humanitarian efforts.
- Developing a Partnership with BAPS Care International: CDC is collaborating on pandemic influenza preparedness planning with BAPS Care International which is a Hindu 501(c) (3)-registered nonprofit international public charity active in health and disaster relief efforts.
- Developing a pandemic planning course for FBCOs in partnership with the Extension Disaster Education Network (EDEN). CDC is working with EDEN to develop a pandemic influenza training that will be delivered through the Land Grant University system which includes Land Grant Universities in each of the 50 states and extension agents in the counties of each of the states.
- Delivering numerous presentations about pandemic planning and emergency preparedness to FBCOs. For example, CDC staff will give a presentation on Pandemic Influenza Preparedness at the Progressive National Baptist Convention, Inc. Christian Education Summit in January 2007 in Houston, Texas. This network includes 2.5 million pastors, teachers and leaders in African American communities across the U.S., United Kingdom, Africa, Bahamas, Cuba and throughout the world.

Emphasize Faith Based and Community Solutions: Meet the OMB mandated "Green" Standards for Success and Best Practices Referenced in Standards. CDC has taken several critical steps to ensure that it is meeting the OMB "Green" Standards for Success by:

- Participation in the FY 2006 Annual Report to the White House Office of Faith-Based and Community Initiatives data collection efforts.
- Reporting efforts to educate agency staff on the requirements of the HHS Equal Treatment Regulations.
- Supporting numerous White House Office of Faith-Based and Community Initiatives Regional Conferences and Workshops. These targeted workshops are designed to help FBCOs learn more about President Bush's Faith-Based and Community Initiative and offer grant writing tutorials for certain Federal grant programs that present some of the greatest opportunities for FBCOs.
- Referring FBCOs to sign up for the HHS CFBCI Weekly Digest for Faith-Based and Community Organizations. This weekly digest summarizes grant opportunities at CDC and HHS for which faith-based/community organizations are eligible to apply.
- Collaborating with other federal agencies and offices on Grant Writing Workshops for FBCOs and panel reviews, for example:
  - On March 28-30, 2006, attended the Faith-Based and Community Partners' Grant writing and Fund Development Project sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).

- On May 10-11, 2006, attended U.S. Department of Housing and Urban Development, Atlanta Regional Office, Region IV- Grant Writing Workshop
- On July 17-28, 2006, provided staff to serve as a Priority Area Manager for HHS Administration for Children & Families Compassion Capital Fund mini-grant & youth gangs programs' panel reviews.

Support community-based approaches to reduce health disparities that affect racial, ethnic, and under- served populations. Some examples of community-based approaches to reduce health disparities include the following:

- Rapid HIV testing initiative with African American Churches for 2007 National Black HIV/AIDS Awareness and Information Day. CDC is leading a collaborative project involving Recovery Consultants of Atlanta, Inc., the Institute for Health Protection, the United Way of Atlanta, CDC National Center for HIV, Hepatitis, STD and TB Prevention, SAMHSA, CMS, the African Methodist Episcopal (AME) church and the Interdenominational Theological Center on a Rapid HIV testing initiative with African American Churches as part of the 2007 National Black HIV/AIDS Awareness and Information Day.
- Presentation at the 2007 National Immunization Conference. From 1995 to 2005, while immunization rates for recommended childhood vaccines increased approximately 20% nationally, they increased more than 30% in Jefferson County, AL. This presentation will discuss Shepherd's Watch, a partnership between the Jefferson County Health Department and 38 churches representing diverse racial/ethnic communities. The county health department facilitated partnerships between eight churches and five medical centers to host eight free immunization clinics in urban areas; provided Shepherd's Watch partners with quarterly updates on immunization activities and recommendations; provided education to over 15,000 congregants; and gave technical assistance on how to implement immunization follow-up programs.
- Two-day consultation meeting on Faith and HIV Prevention. In February 2006, CDC's National Center for HIV/AIDS, STD, and TB Prevention held a two-day consultation meeting with 29 leaders from many faiths, including Protestant, Catholic, Jewish, Hebrew-Israelite, Muslim, and Buddhism.
- National Coalition of Pastors' Spouses. CDC's National Diabetes Education Program is working with the National Coalition of Pastors' Spouses, a national health and wellness initiative embedded in African American churches which focuses on health disparities.
- AME Church, 2006 influenza vaccination clinic pilot. Staff from CDC's National Center for Immunizations and Respiratory Diseases provided technical assistance to AME health officials as part of AME Church's influenza vaccination campaign.
- Samuel DeWitt Proctor Conference. In February 2007, CDC's Emergency Communications System will present on emergency communications, including pan flu at a session entitled "Emergency Preparedness Is Not An Option" during this nationally known Faith-based conference involving historically African-American churches.
- CDC session at 2006 Global Summit on AIDS and the Church. Various CDC staff presented a session at the Global Summit on AIDS and the Church, Nov. 30-Dec. 1, 2006. The Purpose Driven network includes over 400,000 church leaders and congregations in every country. CDC presented information about HIV/AIDS, malaria, tuberculosis, and diseases from unsafe water affecting vulnerable populations in developing countries.
- Safe Water Projects with FBCOs. CDC is working with Emory University School of Public Health, Emory Interfaith-Health Program, CARE and other international NGOs and FBCOs to identify ways to equip FBCOs for Safe Water Projects which aid vulnerable populations in developing countries.
- FBCO Personal Health Record Initiative. This initiative will illume how Personal Health Records (PHRs) can empower and improve the quality and efficiency of health care for African Americans, as well as, how social and physical transactions among clergy, congregants and the community can influence PHR adoption in the African American community

Inform and educate federal grantees, including state and local officials who administer funds, about the requirements of the Equal Treatment regulations. The HHS Equal Treatment Regulations are designed to remove barriers to the participation of FBCOs in HHS programs. CDC ensures that staff and partners are aware of these regulations in several ways:

- CDC distributed the HHS Equal Treatment Regulations through the Association of State and Territorial Health Officials, the National Association of Local Boards of Health, and the National Association of City and County Health Officials to state and local public health agencies administering CDC grants/cooperative agreements

- CDC distributed the HHS Equal Treatment Regulations to each of the CDC Faith-Based and Community Initiative Coordinators, the official point of contact for all FBCI activities within each CIO
- CDC has included the HHS Equal Treatment Regulations in the 2006 CDC Partnership Toolkit developed by the Division of Partnerships and Strategic Alliances
- CDC hosted Mr. Greg Morris, Director of the HHS Center for FBCI and his staff, who presented on the HHS Equal Treatment Regulations at the August 2006 CDC FBCI Coordinators monthly meeting in Atlanta, GA
- A link to the HHS Equal Treatment Regulations will be posted on the CDC intranet